MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."

Report Number: 202504082

Date Issued: July 3, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

New Transitions Inc.
342 Mcindoe St.
Owatonna, MN 55060

New Transitions, Inc.
228 Hazen St.
Waterville, MN 56096

License Number and Program Type:

1122541-H_CRS (Home and Community-Based Services-Community Residential Setting)
1072353-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) was under the influence of a substance while driving a vulnerable adult (VA) to a medical appointment.

Date of Incident(s): May 12, 2025

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (a):

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on May 27, 2025; from documentation at the facility and law enforcement (LE) records; and through six interviews conducted with the VA, two facility supervisors (P1-P2), a medical professional (MP), the VA's guardian (G), and the SP.

Facility documentation showed the VA's friends and family were very important to the VA. The VA enjoyed playing cards, knitting, and going to the casino. The VA preferred "honest" talks with staff persons that would provide "coaching" with tasks. The VA was diagnosed with anxiety, adjustment disorder, paranoid schizophrenia, and multiple physical health issues including lumbar spina bifida with hydrocephalus. The VA used a wheelchair, and staff persons provided assistance to the VA by transporting the VA to community events or appointments. The VA may become confused while providing medical information to his/her care team due to memory issues but did not have a history of providing false information.

The facility completed an *Internal Review* (IR) which stated that on May 12, 2025, the SP transported the VA to a medical appointment, however there were concerns the SP was under the influence of a substance. The VA said the SP drove unsafe and described it as slowing on the highway. The medical facility observed the SP appearing disoriented, talking to him/herself, and was unresponsive to redirection. LE was contacted and the SP was removed from the medical facility. The SP was released from LE custody after LE determined the SP's behavior may have been the result of prescribed medication.

LE records provided the following information:

- On May 12, 2025, at 3:05 p.m., LE were dispatched to a medical facility due to a concern regarding the SP. The SP's behavior was described as "making strange comments and twitching."

- LE was informed the SP was not seen driving the vehicle, but the VA was unable to drive, and they were the only people who arrived in the vehicle. The SP informed LE s/he had drove the VA to the medical facility. The medical facility provided a video recording which showed the SP stumbling while walking up to the front doors of the medical facility.

- LE interacted with the SP and noted the SP did appear to be acting "strange." The SP had a "thousand-yard stare," was shaking, and had difficulty pronouncing words. The SP denied taking any medications and said s/he was tired. After additional questions the SP said s/he took some prescribed medications in the morning. The SP also stated s/he had been in a recent vehicle accident, and multiple prescription pill bottles were located inside the facility vehicle.

- LE had the SP complete a *Horizontal Gaze Nystagmus* (HGN) and did not observe any signs of impairment in his/her eyes. The SP was observed swaying during the duration of the test.

- LE attempted to have the SP complete a *Walk and Turn* test, however once in the starting position the SP said, "I can't do this test," due to balance issues. The SP requested to "pee in a cup," and LE determined the SP was unwilling to continue with additional testing.

- The SP completed a *Preliminary Breath Test* (PBT) to rule out the presence of alcohol, and the test showed a *Blood Alcohol Concentration* (BAC) of ".000."

- A *Drug Recognition Evaluator* evaluated the SP and there was probable cause to arrest the SP for suspicion of driving while impaired. LE attempted to complete a full evaluation, but the SP was unable to complete multiple tests, and thereafter LE determined based on test completed that LE did not believe the SP was impaired by any substances. LE released the SP without charges and informed him/her that s/he was detained due to strange behavior that was likely a result of medical related issue, and not impairment.

The MP said upon arrival the SP was observed to be having odd behaviors that included having difficulty walking and talking to a wall. LE and facility administration was contacted while the VA was in his/her appointment. The VA had no further contact with the SP, as s/he remained with medical personnel until the facility administration arrived. The MP said the SP had previous been to the medical facility and had not engaged in the observed odd behaviors.

P1 said on May 12, 2025, s/he interacted with the SP two hours prior to the medical appointment, and the SP did not display any concerning behaviors at that time. P1 was informed that after the SP and the VA arrived at the medical facility the SP was observed acting oddly by medical personnel and they believed the SP was unsafe to provide care to the VA. P1 said the odd behavior included the SP talking to a wall and having jerky body movements. P1 went to the medical facility after the facility was contacted regarding the concern, but did not interact with the SP. P1 said LE found multiple prescription medications within the SP's belongings, and LE detained the SP due to suspicion of driving under the influence. P1 said the SP had been in a recent car accident, but was not aware the SP was taking any medications while working.

P2 provided consistent information as to that of P1 regarding the incident on May 12, 2025. P2 added that during a conversation on May 13, 2025, the SP stated s/he had oxycodone in his/her system.

The VA said the SP drove him/her to a medical appointment and did not have any concerns for his/her safety when the SP was driving. The VA said s/he had noticed the SP behavior being more energetic than normal, but the VA was not harmed at any time while the SP provided care and supervision.

The SP provided the following information:

- The SP said s/he was driving to the appointment s/he felt tired, did not remember acting abnormally while at the medical appointment. The SP said LE arrested him/her on May 12, 2025, but was later released and cleared of any drug impairment.

- The SP said s/he was in a car accident on May 9, 2025. The SP was seen by a medical doctor that evening. The SP was prescribed oxycodone, but did not have any work restrictions. The SP said s/he took a dose of oxycodone on the evening of May 11, 2025, but denied taking the medication, or any other substances,

while working on May 12, 2025. The SP had a follow-up appointment with his/her primary doctor on May 13, 2025, and was diagnosed with a concussion.

The G was contacted, and did not have any direct knowledge of the alleged incident. The G had been informed of the alleged incident by facility administration.

P1, P2, and the SP were each trained on the VA's plans, the facility's policies and procedures, and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

Conclusion:

On May 12, 2024, the SP transported the VA to a medical appointment. While at the medical facility the SP was observed engaging in odd behaviors such as talking to walls, having difficulty walking, and jerky body movements. LE was contacted and the SP completed multiple impairment tests and was detained by LE. Later in the day the SP was released without charges as the VA behavior was not related to substance use.

The VA said the SP drove him/her to a medical appointment and did not have any concerns for his/her safety when the SP was driving. The VA said s/he had noticed the SP behavior being more energetic than normal, but the VA was not harmed at any time while the SP provided care and supervision.

P1 observed the SP at the facility prior to the SP transporting the VA, and did not have any concerns related to the SP's behavior. The VA said the SP was more energetic than normal but did not have any concerns with the SP's driving, and the VA was not harmed during the incident. There was no information the SP drove dangerously while transporting the VA. Although the SP informed P2 that there would be oxycodone in his/her system, the SP denied using oxycodone or any other substance on May 12, 2025.

Although the SP was observed engaging in odd behavior at the medical facility while providing supervision to the VA, LE determined the behavior was not related to substance use and the SP's blood alcohol level was .000. In addition, the SP more likely than not had a medical condition such as a concussion that the SP was not aware of at the time of the incident. Given the above, and that the VA was not injured, there was not a preponderance of the evidence as to whether the SP failed to provide the VA with reasonable and necessary care and services.

It was not determined whether neglect occurred (the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate, and followed. There were no prior similar allegations, and no additional training was completed. The SP no longer worked at the facility.

Action Taken by Department of Human Services, Office of Inspector General:

No further action was taken.