DEPARTMENT OF HUMAN SERVICES

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: 202504539

Date Issued: July 11, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

Wingspan Life Resources
500 Portland Place
Bloomington, MN 55420

Wingspan Life Resources
30 East Plato Blvd
St Paul, MN 55107

License Number and Program Type:

1069348-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069342-HCBS (Home and Community-Based Services)

Investigator(s):

Parkin, Anna
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242

Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA) was "upset" with a staff person (SP) so the VA pushed the SP. The SP grabbed the VA's face, scratched the VA's neck, and punched the VA in the right side of his/her jaw. The VA sustained scratch marks on his/her neck.

Date of Incident(s): May 25, 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 subdivision2, paragraph (b), clause (1):

Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on June 9, 2025; from documentation at the facility, law enforcement records, and medical records; and through six interviews conducted with a supervisory staff person (P1), three facility staff persons (P2, P3 and the SP), the VA, and the VA's guardian (G). Another supervisory staff person (P4) was interviewed by law enforcement and his/her information was provided below.

The VA was diagnosed with borderline personality disorder and mood disorder. The VA had 3:1 staffing during awake hours. The VA had two piercings in his/her lower lip.

According to the VA's *SP Addendum and Support Self-Management Assessment*:

- The VA "struggle[d] to provide respectful interactions when escalated," was unable to take responsibility during a situation when s/he chose to act impulsive, and lacked the ability to take accountability for a situation that had a negative outcome. The VA "struggle[d] to be honest" to him/herself and other persons s/he communicated with.

- The VA had a history of physical aggression toward other persons. When the VA became frustrated, s/he yelled, swore, or called persons names. The VA also threatened the safety of other persons.

- The VA was not able to accurately discuss his/her feelings when s/he was dysregulated, anxious, or felt like s/he cannot trust a person.

According to the VA's *Individual Abuse Prevention Plan*:

- The VA was not able to identify an abusive situation or recognize danger. The VA had a history of verbal and physical aggression that increased his/her risk of being harmed by other persons. The VA also engaged in behaviors that provoked other persons and may not be able to defend him/herself against physical abuse. The VA may "play the victim role" in which s/he reported needing to either physically or verbally aggress toward other persons if the VA felt they were "disrespectful" or "came at" the VA.

- Staff persons redirected the situation and explained to the VA what behavior was appropriate in the situation and observed the VA for behavioral, emotional, and physical changes which indicated abuse occurred. Staff persons verbally redirected and used de-escalation techniques as they were trained by the facility.

- If the VA became aggressive towards a person, staff persons intervened to stop the aggression, used a blocker or placed furniture/space between the VA and other persons.

The VA provided the following information:

- On the day of the incident, while in the kitchen, the VA asked the SP to make a smoothie. The SP, who was sitting in a chair, said s/he would make it in five minutes. After ten minutes, the VA was "upset,"

"lunged" at, and pushed the SP. The SP stood, grabbed the VA's face, and knocked the VA's glasses off his/her face. The SP also put his/her fingernails "into" the VA's face, mouth, and neck which resulted in scratches on the VA's face, neck, and bleeding from inside his/her mouth.

- The SP and the VA ended up in the living room where the SP used both of his/her hands to grab onto the VA's shirt and then threw the VA down onto the couch. The SP pushed the VA face down on the couch and was on top of the VA. The VA was bleeding from his/her mouth and told the SP to get off but the SP refused.

- The VA cried and asked P3 to call 9-1-1 so P3 did. The VA also had a scratch on his/her left wrist and had three "big" bruises on his/her chest from the SP holding the VA down.

Photos taken two minutes after the incident showed the corner of the VA's lower lip bleeding near a piercing and two scratches on the right side of the VA's neck. The VA did not have pictures of the scratch on his/her wrist but showed an old injury to this investigator. The VA did not have pictures of the bruises on his/her chest and stated that the bruises disappeared a few days after the incident.

The law enforcement report provided the following information:

- A law enforcement officer (LEO1) spoke to the VA who provided the following information:

  - The VA asked the SP to make the VA a smoothie and the SP asked the VA to wait five minutes. Five minutes passed and the SP did not make the VA it so the VA "charged" the SP "aggressively."
  - The SP did not attempt to deescalate the VA, instead the SP "pushed" the VA in his/her face and as a result the VA's glasses were knocked off his/her face. The SP then put his/her finger inside the VA's mouth so the VA bite the SP's finger. The VA wanted the SP charged with assault.
  - Staff persons were allowed to use physical restraints on the VA to deescalate the VA when s/he was "angry." Most staff persons did the restraints correctly but the SP did not do it "appropriately."

- LEO1 saw the VA's lower lip was bleeding "from one of the piercings" and the VA had a cut on his/her finger. LEO1 tried to talk to P2 about the incident but P2 was "reluctant" and did not provide information.

- Another law enforcement officer (LEO2) spoke to the SP who stated that when the VA asked the SP for a smoothie, s/he was "busy" and asked for a couple of minutes but the VA got "angry" and "attacked" the SP. The SP tried defending him/herself and somehow was bit by the VA or the SP's finger was "caught" in the VA's lip piercing. LEO2 noted that the SP's finger was "slightly" bleeding.

- LEO2 called the G who said that the VA was "less stable as of late" and liked getting attention from going to the hospital. Staff persons were trained on restraining the VA and it was "not necessary" for the VA to go to the hospital.

- LEO2 spoke to P4 on the phone who said that the VA was "likely the issue" and not staff persons. Staff persons were trained on restraining the VA when s/he was "out of control."

- LEO2 spoke to P3 who said s/he saw the incident and that the VA was "mad" at the SP for not getting him/her food right away and attacked the SP. P3 and the SP restrained the VA and "no assault occurred."

- The VA requested to go to the hospital and it was determined the "safest course of action for everyone involved" to do so. The VA was transported to the hospital by ambulance. LEO1 determined that no criminal assault occurred and closed the report.

The VA's medical records provided the following information:

- On May 25, 2025, the VA was seen in the emergency room for a facial injury. The VA told a nurse that s/he asked a staff person (later identified as the SP) to make him/her a smoothie. The staff person asked the VA to wait five minutes and after five minutes, the VA "pushed" the SP. The SP "grab[bed]" the VA's face which resulted in the VA's glasses coming off. The SP then "punched" the VA which resulted in the VA's mouth bleeding. The SP stuck his/her thumb into the VA's mouth so that the VA bit it and the SP had "something to show" law enforcement.

- The VA said s/he had "pain" in his/her right side of his/her jaw and neck. The VA also felt "lightheaded" but did not lose consciousness. The VA did not feel comfortable going back to the facility.

- The VA was diagnosed with a lower jaw injury but imaging showed no traumatic injury or fracture. The VA had dried blood on his/her lower lip that was "likely trauma to piercing causing transient bleeding." The VA was administered extra strength acetaminophen.

P2 and P3 provided the following information:

- On the day of the incident, the VA asked the SP to make a smoothie. The SP was sitting at the table eating so asked the VA to wait five minutes. P2 and P3 each then offered to make the smoothie but the VA said s/he wanted the SP to make it. During that time, the VA came and sat down in front of the SP on a chair.

- After two minutes, the VA "lunged" at and grabbed the SP by the hair with both hands and started pulling and hitting the SP in the head. The SP tried to pull his/her hair away and get distance from the VA. The SP had medical gloves on his/her hands and the glove became caught in the VA's lip piercing when s/he tried pulling away from the VA.

- P2 and P3 got behind the VA and each held onto one of the VA's arms. P2 and P3 walked the VA backwards and over to the couch while the VA continued holding onto the SP's hair. P2 and P3 were not able to see what the SP was doing when they were behind the VA.

- P2 and the VA sat on the couch for two minutes and the VA eventually let go of the SP's hair. During that time, the VA noticed his/her lip was bleeding so P3 called 9-1-1. The VA kicked at and tried biting P2 and the SP. P3 saw the VA's lower lip bleeding and two scratches on the VA's neck. P3 did not know how the VA got scratched on the neck. P2 saw the VA's lower lip bleeding and the SP's finger bleeding. P2 continued talking to and calming the VA until law enforcement arrived.

The SP provided the following information:

- The VA asked the SP to make him/her a smoothie and when the SP asked the VA to wait, the VA got a chair and sat in front of the SP to "intimidate" him/her. The VA then grabbed the SP's hair and pulled with both hands. The SP held onto his/her own head/hair so it would not get pulled out. The SP's head was down during that time. P2 and P3 tried getting the VA to let go of the SP's hair.

- During the interaction, the VA bit the SP's finger. As the SP pulled his/her finger out of the VA's mouth, the VA's lip piercing got caught on the SP's glove and the piercing "moved." The VA then began to punch so the SP first used his/her hands to "block" his/her face and then put his/her hands on the VA's wrists "for less than a minute" to stop the punches.

- P2, P3, and the SP got the VA to sit on the couch in the living room. P2 used his/her legs to block the VA's kicking and the SP had his/her arms around the VA's chest holding onto the VA's wrists. Once the VA stopped hitting and kicking, the SP let go of the VA's wrists and went to the bathroom. The only injury the SP saw on the VA was that his/her lip bleeding. The SP was not aware of the scratches on the VA's neck.

P1 provided the following information:

- On May 27, 2025, the VA called P1 about an unrelated incident. During the conversation, the VA said s/he "lunged" at the SP so the SP put his/her hand up to block the VA and the VA's chin hit the SP's hand. The SP's finger went into the VA's mouth so the VA bit the SP's finger. When the SP pulled his/her finger out of the VA's mouth, it caught on the VA's lip piercing which resulted in it bleeding. The SP placed the VA in a hold face down on the couch for five minutes and P2 and P3 did not intervene.

- P1 then spoke to P2, P3, and the SP about the incident. The SP demonstrated how s/he placed the VA in a restraint. P1 said it was how the SP was trained except that staff persons were "more in defensive mode" at the time of the incident including when the VA pulled on the SP's hair, P2 came over and placed one arm over the VA's upper arm instead of under it. Also, when the VA bit the SP's finger, the SP was trained to push towards the VA's mouth instead of pulling away. P2 and P3 followed their training by properly holding the VA's arm and blocking the VA's feet when s/he kicked them.

- The VA had a history of telling one piece of a story that was true and then exaggerating other parts.

The G stated that P4 notified the G about the incident but the VA had not discussed it which was "strange" because the VA wanted the G to know "everything." The VA had a history of being "dangerous" and the G did not have concerns with staff persons' physical interactions during the incident.

According to the facility's *Emergency Use of Manual Restraints Policy*:

- The facility promoted the rights of clients and protected their health and safety during an emergency use of manual restraints. Emergency use of manual restraints meant using a manual restraint when a client posed an imminent risk of physical harm to themselves or other persons and was the least restrictive intervention that achieved safety.

- The following positive support strategies and techniques were used to try and deescalate the client's behavior before it posed an imminent risk of physical harm: following the client's annual plans; shifting focus by verbal redirection to an alternative activity; modeling positive behavior; reinforcing appropriate behavior; offering alternative choices; actively listening to the client and validating his/her feelings; creating a calm environment; speaking calmly with reassuring words; and respecting the need for space and privacy.

- Physical contact or instructional techniques were used the least restrictive alternative possible to meet the client's needs and were used to block or redirect a client's limbs or body without holding the client or

limiting their movement to interrupt the client's behavior that may result in injury to themselves or other persons.

- The facility allowed staff persons to physically escort/walk or arm restrain a client on an emergency basis when the client's conduct posed an imminent risk of physical harm to themselves or other persons and when less restrictive strategies did not achieve safety.

- If a client had escalated behaviors and it was necessary to move the client, staff persons used the following steps of physical escort/walking:

    - The staff person walked side by side but slightly behind the client. Staff persons used their hand closest to the client and placed it on the client's forearm just below the elbow with "firm but gentle pressure."
    - If this was not effective, staff persons used both hands to move the client while walking. Staff persons moved their hand from the client's forearm to the small of their back and applied firm but gentle pressure.

- If a client had escalated behaviors, staff persons used a one arm standing restraint by directing one of the client's arms forward to cross in front of the client's body by applying "slight pressure" above or below their elbow. With the staff persons' other arm, they "lightly gripped" the client's crossed arm slightly above the wrist and held the arm in the cross position. The staff person then slid their free arm between the client's arm and waist to grip the forearm. Staff persons palms faced down.

- The restraint ended when the threat of harm ended.

Facility documentation showed that staff persons, including the SP, were trained on the VA's plans, the facility's *Emergency Use of Manual Restraints Policy,* and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

Conclusion:

Information was consistent that on May 25, 2025, the VA aggressed towards the SP including pulling the SP's hair. P2, P3, and the SP provided consistent information that P2 and P3 immediately intervened and that the VA was restrained and moved to the couch.

Although the VA had bleeding from his/her lip piercing and had scratches on his/her neck, given that the VA was physically aggressive towards the SP it was reasonable and necessary for staff persons to intervene; that information from P1, P2, P3, and the SP was consistent that during the incident, staff persons' interactions were consistent with their training; that the VA's lip injury most likely occurred when the SP pulled his/her finger out of the VA's mouth when the VA was biting it; and that P2 and P3 said that because they were behind the VA they did not see all of the SP's interactions with the VA, there was not a preponderance of the evidence whether all of the SP's actions were therapeutic conduct or whether the VA sustained the injuries by any means other than accidental.

It was not determined whether physical abuse occurred (Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable

adult).

Action Taken by Facility:

The facility completed an *Internal Review* and determined that policies and procedures were adequate but not followed. Staff persons did not immediately follow reporting of possible abuse policies and there was a delay in completing the emergency use of manual restraint internal review. Staff persons received additional training on emergency use of manual restraints, reporting alleged maltreatment, and positive support strategies for supporting the VA.

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

No further action taken at this time.