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: 202505954

Date Issued: October 2, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

Opportunity Partners - Girard
6726 Girard Ave S
Richfield, MN 55423

Opportunity Partners Inc
5500 Opportunity Ct
Hopkins, MN 55343

License Number and Program Type:

1073219-H_CRS (Home and Community-Based Services-Community Residential Setting)
1073209-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

It was reported that there were concerns with a staff person's (SP) interactions with two vulnerable adults (VA1 and VA2), including yelling at and "scaring" VA1.

Date of Incident(s): unknown

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 2, paragraph (b), clause (2):

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: the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on July 24, 2025; from documentation at the facility; and through 13 interviews conducted with four supervisory staff persons (P1-P3 and the SP), three facility staff persons (P4-P6), VA1, VA2, two other clients (C1 and C2) who resided at the facility, and VA1's and VA2's respective guardians (G1 and G2).

Initial information provided by P1 and P2 was there were concerns that the SP "took away" VA2's alone time in the community and forced VA2 to go to his/her day program on his/her birthday when s/he wanted the day off. Through interviews and documentation there was no information that corroborated these concerns, therefore this investigation memorandum will only address the concerns with VA1.

VA1 was diagnosed with a mild developmental disability. VA1's plans did not address potential emotional abuse.

P1 and P2 provided the following information:

- On July 3, 2025, at approximately 10 p.m., VA1 told P2 that s/he had concerns with the SP, including yelling at VA1 when the SP was "angry." VA1 stated it happened when other staff persons were not around but the VA was not able to provide specific examples. VA1 also said s/he was "scared" of the SP because on one occasion, when VA1 asked about having his/her family members visit for a special occasion, the SP said no because of staffing.

- Shortly after, P2 asked C1 how s/he liked staff persons and C1 said that the SP "yelled" at VA1, VA2, C1, and C2. C1 then laughed and went into his/her bedroom. On July 7, 2025, P2 emailed P1 about the concerns.

- P1 was not aware of VA1 having prior concerns with the SP. VA1 was a "people pleaser" and was not always accurate when providing information and VA1 also did not want the SP to "get in trouble." P2 rarely worked direct care so was not able to provide information on the accuracy of VA1's statements but said that the SP's approach to the clients was not always person centered.

VA1 stated that the SP was "hard to get along with" and had his/her "own ways of doing things" but did not provide specific examples. The SP yelled at VA1 "a couple of times" that "could have been" two to three years previous to this investigation but was not able to provide more specific information.

VA2 stated that the SP recently "raised" his/her voice "a little bit" at the clients when s/he was "stressed" but denied that the SP yelled at clients. VA2 did not have any other previous concerns with the SP's interactions with VA1.

P3 stated on one previous occasion approximately one week prior to July 9, 2025, VA1 told P3 that s/he was

"scared" of the SP and did not like the rules s/he enforced such as VA1 bathing before going on an outing. VA1 did not provide any other additional information. On July 9, 2025, VA1 told P3 about his/her conversation with P2, including that s/he was "scared" of the SP. P3 asked VA1 multiple questions and VA1 clarified that s/he was "scared of consequences" from the SP. P3 thought P1 and P2 "misunderstood" what VA1 tried telling them. VA1 was "paranoid" and did not always tell the truth. P3 did not have concerns with the SP yelling at the clients or his/her interactions with the clients.

C1 denied hearing staff persons yell. C2 stated on one previous occasion, while inside his/her bedroom, s/he heard an unknown staff person yelling but was not able to provide any additional information. C1 and C2 denied having concerns with staff persons, including the SP.

P4 stated that VA1 had a history of "sometimes misinterpret[ing]" things or worded things in a way that was "difficult to understand." The SP was "firm but fair" with the clients and P4 "never" had concerns with the SP's interactions with them.

P5 and P6 each denied hearing the SP yell at clients and did not have concerns with his/her interactions with the clients.

The SP stated s/he worked two to three days per week at the facility. VA1 was "always super happy" to see the SP. The SP had not noticed any recent changes in VA1's interactions with the SP and the SP denied yelling at or scaring VA1.

G1 stated that VA1 had a history of incorrectly relaying information about incidents. G1 knew the SP for eight years and did not have any concerns.

G2 did not have any previous concerns with the SP or the facility prior to this investigation.

According to the facility's *Policy on Code of Conduct*, staff persons had a commitment to the clients and "working in service to" rather than controlling the clients. Staff persons created a mutually respectful and positive environment.

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

Conclusion:

On July 3, 2024, VA1 told P2 that s/he had concerns with the SP, including yelling at VA1 when the SP was "angry." VA1 stated it happened when other staff persons were not around but was not able to provide specific examples. VA1 also said s/he was "scared" of the SP. On one occasion, when VA1 asked about having his/her family members visit for a special occasion, the SP said no because of staffing.

Although VA1 told this investigator that the SP was "hard to get along with," had his/her "own ways of doing things," and the SP yelled at VA1 a couple of times, VA1 did not provide specific examples. Given that there were concerns with VA1's accuracy and interpreting information; and that P4-P6 who provided direct care to VA1 did not have concerns with the SP's interactions with VA1; and there was no additional information that it was a repeated or malicious by the SP1, there was not a preponderance of the evidence whether the SP1's actions were

repeated oral language or treatment of VA1 that would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening and could reasonably be expected to produce emotional distress.

It was not determined whether emotional 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: the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening).

Action Taken by Facility:

The facility completed an *Internal Review* and determined that policies and procedures were adequate and followed. The SP and P3 no longer work at the facility.

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

On October 2, 2025, the facility was issued a Correction Order for not reporting suspected maltreatment timely.