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: 202507037

Date Issued: October 3, 2025

Name and Address of Facility Investigated:

Dungarvin Minnesota LLC
16345 Duluth Ave SE
Prior Lake, MN 55372

Dungarvin Minnesota LLC
1440 Northland Dr Ste 100
Mendota Heights, MN 55120

Disposition: Inconclusive as to physical abuse and false as to emotional abuse.

License Number and Program Type:

1120791-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070806-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 a staff person (SP) grabbed a vulnerable adult's (VA) arm, which caused a bruise and asked the VA why s/he was being a "brat."

Date of Incident(s): August 5, 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 2, paragraph (b), clauses (1) and (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:

- Hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

- 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 August 25, 2025; from documentation at the facility; and through seven interviews conducted with two facility supervisory staff persons (P1 and P2), two facility staff persons (P3 and P4), the VA's case manager (CM), the VA's guardian (G) and the SP.

The facility was a split entry home in a residential neighborhood with two separate living areas, one upstairs and another downstairs. The VA lived downstairs, and upon entering the VA's residence, there was an open layout with the kitchen to the right and living room to the left. Straight ahead was a short hallway. The first door on the right of the hallway was the bathroom, followed by a second door that was a closet. The VA's bedroom was at the end of the hallway. The entire layout of the residence was visible from the entry door; however, the inside of the bathroom and the VA's bedroom were not visible.

The VA was diagnosed with severe intellectual disabilities, static encephalopathy, hemi-megalocephaly-agyria, left cerebral dysplasia, right side hemiplegia and had a history of seizures. The VA required a 24-hour plan of care with assistance of staff person to complete his/her activities of daily living, cognitive and behavioral direction, and medical needs. The VA had a history of physical aggression, verbal aggression, leaving the facility without staff persons supervision, and self-injurious behaviors. The VA enjoyed going on outings with the G, watching movies, being active in the community and assisting with household tasks. The VA was partially verbal but due to his/her diagnoses the VA was unable to provide information for this report.

The VA's *Self-Management Assessment* and *Individual Abuse Prevention Plan* each stated that if the VA felt overwhelmed, s/he would engage in "hitting, biting, kicking, punching, throwing items, and yelling/screaming at others." Staff persons used "proactive positive supports" such as looking at pictures and turning on music or television to prevent the VA's behaviors from escalating. If those did not work, staff persons verbally redirected the VA to a safe area and encouraged the VA to use his/her coping skills.

The VA's *Behavior Plan* stated the VA could "escalate out of the blue" and was triggered by the words "no, stop, don't, and quit," as well as repeated demands and "power struggles." When the VA escalated, staff persons offered the VA two preferred activities, maintained a calm voice, avoided power struggles, and refrained from having visible emotional reactions to problem behavior. The VA responded well to "enthusiastic" behavior, specific verbal praise and was "highly reinforced" by attention and verbal encouragement by staff persons.

The facility's *Bruise Protocol* stated that staff persons were responsible to monitor for presence of bruises on the VA and to document the location, size, and date the bruise was noticed. If a bruise did not heal, staff persons were to notify the VA's medical provider and upload a photograph of the bruise with any detail regarding the bruise.

P3, P2, and P4 provided the following information:

- P3 stated that on August 5, 2025, at 6:55 a.m. when s/he arrived at the facility, s/he heard the shower running. P3 started work on a computer at a table in the kitchen when the SP exited the bathroom looking for a towel. P3 thought the SP was "agitated" because after getting a towel, the SP "slammed" the closet door. P3 also heard the VA yelling and screaming in the bathroom, which was typical for the VA when s/he was agitated.

- The SP then went back into the bathroom and a short time later P3 heard the VA being "vocal." P3 heard the VA yell and then heard the SP ask, "Why would you grab my arm?" "Why would you do that?" and "Why are you such a brat?" The SP then asked the VA to let the SP "help" him/her, and told the VA, "We don't hit."

- P3 decided to go to the bathroom when the VA started to "scream" and asked for the G. The SP told the VA that the G was coming, when in fact, the G was not. P3 then heard the VA "scream bloody murder" so P3 "ran" into the bathroom and told the SP that s/he would take over so the SP could leave. When P3 got to the bathroom, the VA was in the shower, and the SP was "just standing there." P3 helped the VA finish his/her shower and get dressed, and then the VA watched a movie in the living room. After the VA was dressed, P3 called P1 and told him/her of the incident. P3 waited for P4 to arrive at the facility.

- P4 stated that s/he was scheduled to work from 7:30 a.m. to 3 p.m. and when s/he arrived P3 was making telephone calls and completing documentation while the VA watched a movie. P3 told P4 that there was an incident between the VA and the SP and that P4 could read the documentation. P3 then went outside to complete his/her calls. Later, when P4 reviewed the documentation, it provided information that was consistent with the information P3 told this investigator. At some point, P4 noticed that the VA was rubbing his/her left arm a lot so P4 asked the VA about it. The VA told P4 that his/her arm "hurt" and when P4 looked at the VA's left arm s/he saw what looked like a thumb or fingerprint mark on the VA's arm that was "kind of blue." However, P4 then stated the bruise was on the VA's hand. The VA told P4 that s/he did not know how s/he got the bruise. P4 then went outside and told P3 that the VA said his/her arm hurt and that the VA had a bruise on his/her arm.

- P3 then went inside and looked at the VA's arm and saw a bruise "the size of a thumb [print], a nickel" but did not remember which arm the bruise was on. P3 asked the VA if his/her arm hurt, and the VA stated it did.

- P2 stated that on the day of the incident, at an unknown time after, s/he saw a bruise on the top of one of the VA's arms that "could have been like a thumbprint." P2 did not remember which arm and did not talk to the VA about it.

- P3 stated that the VA required assistance with "pretty much everything" and could be aggressive, easily agitated, and repetitive. The VA needed "consistent redirecting and patience" due to his/her behaviors. When the VA was aggressive, staff persons were trained to ask the VA to have a "calm body" and "safe hands." If s/he was aggressive towards staff persons, they were to "block" the VA's physical aggression towards them.

- P4 stated that the VA had a history of physical and verbal agitation, and P4 had seen the VA hit and pull staff persons hair and when this happened, staff persons were to remind the VA to use safe hands and communicate. Staff persons were trained to be patient with the VA, redirect him/her and offer

suggestions rather than tell the VA to do things.

- P2, P3, and P4 did not have previous concerns with the SP's interactions with clients. P4 stated that the SP was "patient and very nice" to the VA and "very soft spoken" and P4 had never seen the SP yell or call the VA names. P3 also stated that s/he did not know exactly what happened during the incident because s/he was at the kitchen table and not in the bathroom, so s/he only heard the interaction.

P1 provided the following consistent information:

- On an unknown date, P3 called P1 and told P1 about the incident. P3 provided information to P1 that was consistent with the information P3 provided during his/her interview. Later, P2 and P3 called P1 and told him/her that the VA had a bruise on his/her arm and emailed a picture which showed a bruise on what P3 thought was the VA's left forearm that was oval and "less than an inch."

- P1 visited the facility the day after the incident but when P1 tried to talk to the VA, the VA did not want to talk to P1. P1 saw the bruise at that time stated it "looked about the same" as the photograph but was "fading."

- The VA had a history of physical aggression towards staff persons, and staff persons were trained to redirect and give the VA space if s/he had behaviors.

- P1 had no prior concerns regarding the SP's care of the VA.

The SP provided the following information:

- On August 5, 2025, at 7:00 a.m., the SP was working, and the VA's demeanor was "good." The SP asked the VA if s/he wanted to eat breakfast or take a shower. The VA wanted to shower, so the SP went to the bathroom and started the shower. Around 7:06 a.m., before the VA got into the shower, P3 arrived.

- The SP was in the bathroom with the VA and after the VA got into the shower, the SP reached across the VA to get the body wash when the VA "grabbed" the SP's arm. The SP looked at the VA and the VA let go. P3 then came into the bathroom and told the SP s/he could take over. At that time, the SP told P3 to be "extra vigilant" because the VA just grabbed the SP's arm. The SP then left the facility.

- The VA had "moods", and his/her behaviors were "different with everybody." The SP had previously seen the VA slap and get aggressive with staff persons, but the SP thought the VA was easy to work with. If the VA had behaviors, the SP left the VA alone, or talked to the VA to deescalate the VA with things the VA enjoyed, like watching television or talking about the G. The SP also walked around the facility with the VA and looked at photographs. The SP was trained on redirection.

- The SP was "shocked" when s/he was informed of the allegations and stated they "made no sense." The SP denied that s/he or the VA yelled in the bathroom and stated s/he would "never do that." The SP denied that s/he called the VA a "brat," that the word was not in his/her vocabulary, and that s/he would never call anyone that.

- The SP denied that s/he told the VA that the G was coming that day. The SP stated that before the VA got

in the shower, s/he and the VA talked in the VA's bedroom about the G visiting the following day, and that the VA told the SP what s/he wanted to do during that visit. Seeing the G was the VA's "favorite thing", and s/he asked twenty to thirty times a day if the G was coming.

- The SP denied grabbing the VA's arm and did not see any bruises on the VA. The SP was trained to check the VA for bruising and always did so when the VA showered, when the SP started a new shift, and when changing him/her.

The G was aware of and "surprised" by the allegations. The VA had a history of physical aggression and was triggered by having to do things s/he did not want to do, loud sounds, and being surprised. The G thought that the VA had been physically aggressive with every staff person who worked at the facility at some point. If the VA was aggressive, staff persons were to back away and try to calm the VA with words. The SP worked at the facility "for a while" and the G "never" had concerns with the SP's care of the VA.

The CM was aware of the allegations and did not have concerns with the facility as it related to this investigation.

The facility's *Medical Notes* state that on August 5, 2025, at an unknown time, the VA had an "altercation" with a staff person during which the VA "grabbed" the staff persons arm. The medical provider was unclear of the staff persons grabbed the VA's arm back but noted a "small bruise on the middle of [the VA's] right forearm." The VA moved his/her right arm with no obvious signs of a broken bone, and the provider noted that the bruise would "evolve" with healing. Staff persons were told to inform the VA's primary care provider if the VA had additional issues with his/her right arm. There was no additional medical follow up follow up needed.
A photo of the bruise showed a small, blue, circular bruise on the VA's right forearm.

The facility's personnel files showed that prior to this incident, P1-P4 and the SP were all trained on the VA's plans and the Reporting Maltreatment of Vulnerable Adults Act.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245D.06, subdivision 7, paragraph (b), clause (4) states in part that physical contact must use the least restrictive alternative possible to meet the needs of the person and may be used to block or redirect a person's limbs without holding the person or limiting the persons movement to interrupt the person's behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.

Conclusion:

Consistent information was provided that the VA had a history of being physically aggressive with staff persons, and that staff persons were trained to redirect the VA. P3 stated that s/he heard the VA yelling and screaming and heard the SP yelling at the VA, and then heard the SP ask, "Why would you grab my arm?" "Why would you do that?" and "Why are you such a brat?" The SP then asked the VA to let the SP "help" him/her and told the VA, "We don't hit." P3 did not see the SP and the VA while they were in the bathroom, and the VA was unable to provide information about the incident. The SP denied yelling at the VA, calling the VA a "brat," or causing the bruise to the VA.

Regarding physical abuse:

Although the VA had a bruise, information regarding the location of the bruise varied and while the VA did not have the bruise prior to the interaction with the SP in the bathroom, given that based on what P3 heard the SP say to the VA, the VA was being physically aggressive towards the SP, it was most likely that the VA sustained the bruise while in the bathroom. However, the SP denied causing the bruise and the VA hitting the SP would have most likely required the SP to momentarily redirect the VA's limbs. Therefore, there was not a preponderance of the evidence whether all of the SP's actions were therapeutic conduct or whether the VA sustained the bruise 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).

Regarding emotional abuse:

The SP calling the VA a "brat" was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services. However, given it was a single statement on a single occasion and that P1-P4 and the G had no concerns regarding the SP's interactions with the VA, there was a preponderance of the evidence that the single statement would not reasonably be expected to produce emotional distress.

It was determined emotional abuse did not occur (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 facility policies and procedures were adequate and being followed.

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

No further action taken.