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: 202505999

Date Issued: October 23, 2025

Name and Address of Facility Investigated:

Dungarvin Linda Lane
811 Linda Lane
Sauk Rapids, MN 56379

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

Disposition: Substantiated as to neglect of a vulnerable adult by the facility.

License Number and Program Type:

1070871 - H_CRS (Home and Community-Based Services-Community Residential Setting)
1070806 - HCBS (Home and Community-Based Services)

Investigator(s):

Brittany Dolen
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
651-431-6701
brittany.dolen@state.mn.us

Suspected Maltreatment Reported:

It was reported that when a vulnerable adult (VA) moved out of the facility, his/her bedroom smelled of urine and body odor, there was garbage in the bedroom, and rodent droppings on the VA's dresser. The VA's belongings were in trash bags and covered with urine and feces. The VA had not showered for a few weeks and did not have any clean clothes or hygiene items.

Date of Incident(s): Ongoing prior to July 7, 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 July 22, 2025; from documentation at the facility; and through 13 interviews conducted with the VA, the VA's case managers (CM1 and CM2), two facility residents (R1 and R2), two community persons (CP1 and CP2) who worked at the VA's new residential program, four supervisory staff persons (P1, P2, P3, P4), and two facility staff persons (P5 and P6). Attempts were made by telephone and email to speak with the VA's guardian (G); however, the guardian did not respond to those attempts.

The VA was diagnosed with autistic disorder and attention deficit hyperactivity disorder and required assistance with daily living skills, hygiene, medication management, and transportation. The VA enjoyed playing video games and going on outings. The VA moved into the facility on January 29, 2025, from another residential program operated by the same license holder where s/he had lived since October 4, 2024. The VA moved out of the facility on July 7, 2025, to a residential program operated by a different license holder.

The VA's *Individual Abuse Prevention Plan* (IAPP) stated that the VA struggled with hygiene, went "several weeks" without showering, struggled with doing laundry and when the VA went to the bathroom, s/he did not wipe. The IAPP specified that the VA was not susceptible for abuse in this area, and the facility did not list needed support from staff persons related to these issues.

The VA had a *Daily Checklist* which helped the VA keep up on his/her cleaning and hygiene routines, with a goal of the VA completing these 80% of all days and becoming 100% independent in this area. The *Daily Checklist* stated that the VA would shower every other day and wash with soap and shampoo, brush his/her teeth twice daily, wear clean clothing, keep up on his/her laundry and complete laundry when prompted, clear any food/drinks from his/her bedroom after use and follow and complete his/her checklist each day. Staff persons provided the VA counseling and coaching around areas of cleanliness or hygiene that were not completed and provided the VA prompts and reminders on when s/he wanted to complete his/her checklist items.

CM1 and CM2 provided the following information:

- On April 17, 2025, CM1, the G, the VA, P1, P2, and P4 attended a team meeting for the VA at the facility to address concerns with the VA's hygiene. During this meeting, CM1 learned that the VA felt uncomfortable with an unidentified staff person at the facility, and it was learned that the VA would not shower when that staff person was present. P4 was identified as a "safe person" for the VA and would be present in the home when the VA showered. CM1 did not receive updates from the facility on progress regarding the VA's hygiene after the meeting. CM1 did not enter the VA's bedroom while at the facility and was not at the facility again until the day the VA moved out (July 7, 2025).

- On July 7, 2025, CM1 and CM2 went to the facility to assist with the VA with moving out of the facility and into a new residential program operated by a different license holder. CM1 stated that due to a "strong" odor, s/he stood "a few feet" down the hall from the VA's bedroom and due to the VA's body odor, s/he "could not stand next to [the VA]," When CM1 entered the VA's bedroom, the condition was "very bad." CM1 saw garbage, food, soiled clothing, and mouse droppings on the VA's dresser. When the VA removed items from his/her dresser, the VA "pulled up" his/her shirt sleeve and "brushed" the droppings off with his/her arm. CM1 thought the VA was aware of the mouse droppings and "did not care." CM2 stated the VA's bedroom was "unreal" and that there was food under the bed, in the closet, and in the dresser drawers. CM2 saw mouse droppings on top of the VA's dresser and stated s/he could smell the VA's bedroom from the front door of the facility.

- CM1 stated that P1 was present at the time, but did not speak to CM1, CM2, or the VA and did not offer to help. CM1 stated s/he was "frustrated" by this, but did not want to embarrass the VA, so neither CM1 nor CM2 talked to P1 about the condition of the bedroom while at the facility. CM2 thought P1 could hear CM1 and CM2 talking about the condition of the bedroom when they were moving the VA. After leaving, CM1 spoke with the VA about the condition of his/her bedroom. The VA told CM1 his/her bedroom was that way because s/he "did not want to be" at the facility.

- Later, after the VA unpacked at his/her new home, CP1 told CM1 that the VA's pants, pajamas, and sheets were "soaked" with human urine and feces, that there were mouse droppings among the VA's belongings, and that a lot of the VA's belongings were thrown away due to their condition.

- CM1 stated that the VA was unable to take care of his/her own health and safety needs and required reminders and physical assistance with managing his/her medication, scheduling and attending appointments, and ensuring appropriate hygiene. The VA required placement in a facility due to the level of assistance s/he required with maintaining basic tasks. The VA was physically capable of maintaining his/her bedroom but would not do it.

- CM2 stated that the VA needed prompts and reminders for daily hygiene, had "no concept" of his/her basic needs, and was "very bad" with his/her hygiene. The last few times CM2 saw the VA, the VA's skin was "flaking," s/he had dandruff all over his/her clothes, and smelled "horrible." CM2 noticed that the VA's hygiene had been worse for three months prior to the VA moving and when CM2 picked the VA up from the facility, CM2 told the VA that s/he needed to shower due to body odor, and the VA usually responded, "Yeah," or "I will."

- CM1 did not remember if staff persons were responsible for completing room checks for the VA, but part of the VA's plan at the facility was to follow his/her daily checklist related to cleaning and hygiene routines.

- While the VA lived at the facility, CM1 was supposed to see the VA in person at least twice a year, and the G and CM2 were to talk with the VA on the phone monthly.

- On an unknown date, CM2 spoke with the VA about the condition of his/her bedroom and told the VA that s/he could not let his/her bedroom get that like "ever again." The VA responded, "Yeah."

- From January to July 2025, CM1 received one email, dated April 17, 2025, from P2. The email stated that at the VA's meeting later that day, P1 and P2 wished to discuss "concerns" regarding the VA. P2 did not specify what the concerns were, and the email was sent the morning of the meeting.

From January to July 2025, CM2 received no communication from the facility regarding concerns with the VA's hygiene or the condition of the VA's bedroom.
CP1 provided the following information:

- When the VA arrived at his/her new residential program, the VA smelled "absolutely atrocious" and was "filthy, filthy, dirty." CM1 and CM2 acted "appalled" as though they had "no idea" of the VA's appearance and hygiene.

- CP1 helped the VA move in and unpack his/her belongings. When CP1 took the VA's items out of the van, "flies started coming around." As CP1 sorted through the VA's items, flies were "attacking" the VA's property. Every item of the VA's clothing, "the crotch and the butt of [the VA's] underwear, shorts and sweatpants" appeared as though they were "never" washed and that the VA had "used them repeatedly." CP1 found mouse droppings in the VA's dresser, and with the help and permission of the VA, they threw away 80-85% of what the VA brought with him/her due to "biohazard" concerns.

- The only hygiene item the VA had when s/he arrived was a tube of toothpaste and the VA told CP1 that s/he "did whatever [s/he] wanted" at the other facility and that staff persons did not assist the VA with personal cares. CP1 did not ask the VA's questions or take photographs because s/he did not want to make the VA feel uncomfortable.

- Since the VA had been at the new residential program, his/her hygiene was "excellent", and the VA agreed to a plan that they would work and reassess in two-week increments. The first two weeks, the VA showered every day with staff persons providing coaching to the VA on how to use a wash rag and loofa. CP1 thought the VA was "more confident" and "saw the benefit" of the facility providing expectations for the VA's hygiene.

CP2 stated that the VA arrived at the new residential program with "soiled linens and mouse droppings on [his/her] clothing" and a weighted blanket that was "covered in urine." The VA smelled "atrocious" and had no hygiene "supplies." The VA told CP2 that while living at the facility, s/he "felt isolated," spent a lot of time in the basement "unattended," and s/he had not brushed his/her teeth in a month. CP2 was "overwhelmed" and felt "so bad" for the VA. CP2 wanted to clean the VA's belongings, but they had to throw away 80% of the VA's belongings due to their condition. Staff persons at the new facility purchased the VA new clothing and bathing supplies with their personal money, worked with the VA on arranging appropriate services for his/her mental health, and ensured the VA was safe and had healthy hygiene.

R1 stated the VA woke up in the middle of the night to cook food and did not clean up. The VA did not shower and was "very stinky." R1 tried to be polite to the VA and encourage the VA to shower, but the VA was not "educated" on hygiene due to his/her upbringing. R1 was never in the VA's bedroom but could smell the VA's bedroom when the door was open. R1 spoke with staff persons about the VA's hygiene and the smell from the VA's bedroom but did not what staff persons did with that information.

R2 stated the VA needed to take a shower "so bad, a lot" and "smelled something terrible." R2 thought the VA

"just didn't like" to shower. Periodically, R2 told the VA that the VA needed to take a shower, and the VA told R2, "Mind your own business." R2 talked to staff persons about the VA's hygiene and staff persons told R2 they could not make the VA shower. Sometimes, the VA would get fecal matter on the toilet and would not clean it. R2 thought s/he heard staff persons talk about the condition of the VA's room before the VA moved out, but did not remember specific information regarding what s/he heard. R2 did not have concerns with the condition of the facility and did not notice any smells at the facility aside from "how the VA smelled."

The VA stated that s/he was not aware of concerns regarding the condition of his/her bedroom and that s/he showered "at least" bi-weekly and washed his/her laundry "at least" three times per month. The VA initially stated that s/he showered whenever staff persons asked him/her to do so but then stated that staff persons at the facility talked to him/her "possibly multiple times" about the VA's refusing to shower. The VA did not shower when certain staff persons were working because s/he did not like them. The VA stated that whether s/he cleaned his/her bedroom or showered depended on how s/he "felt" that day and whether it was a staff person s/he did not like asking him/her to do so. The VA said there was human feces on his/her clothing but did not provide additional information about how the feces got on the clothes. The VA denied seeing mice at the facility, or rodent droppings in his/her bedroom. Staff persons "never" tried to help the VA clean his/her bedroom. The VA stated that s/he would have allowed staff persons to clean his/her room if they asked to do so.

P1 provided the following information:

- The VA lived at the facility from January 29 to July 7, 2025. The VA had "no awareness" of social situations, was unable to live on his/her own and required assistance with cooking, and prompts for hygiene and "essentially taking care of [him/herself]." The VA often refused to take his/her medications, refused to shower, and refused to let staff persons into his/her bedroom. Staff persons were aware when the VA moved into the facility that hygiene was an "issue" for the VA, because the VA lived at another residential program run by the same license holder, where hygiene was an issue for him/her. On an unknown date, prior to the VA moving into the facility, P1 held a meeting for staff persons to discuss the VA and his/her hygiene needs. P1 stated staff persons read the VA's plans to better understand his/her needs.

- Each shift, staff persons asked the VA to shower and put on clean clothes, and the VA responded that s/he was "not going anywhere" so s/he did not need to shower. The VA did not like showering or putting on clean clothing and wore the same clothing for seven days. The VA also did not clean him/herself thoroughly after having a bowel movement, and P1 did not think the VA knew how to clean him/herself, because when the VA did shower, s/he "still had a smell."P1 spoke with staff persons about how they approached the VA to discuss hygiene, and staff persons told P1 that the VA was not responsive to their attempts to prompt the VA, or discuss his/her hygiene.

- Other residents spoke with P1 about the VA and asked that staff persons talk to him/her because after the VA used the bathroom, there was urine and/or feces on the floor and the VA would not clean it up and the VA smelled "really bad" and P1 reminded staff persons to prompt the VA to shower.

- On an unknown date in June 2025, P3 helped the VA clean his/her bedroom. P3 told P1 that the VA's bedroom was "pretty bad", and it was decided that staff persons would start doing consistent room checks, but the VA would not allow staff persons to go into or look in his/her bedroom.

- The VA left his/her bedroom "often" during the day giving staff persons "a lot" of opportunities to enter the VA's bedroom. However, the VA did not want anyone in his/her bedroom, so staff persons did not enter the VA's bedroom or clean without the VA's consent.

- P1 was not aware of mouse droppings in the VA's bedroom prior to, or after the VA moved from the facility. When the VA moved out of the facility, neither CM1 nor CM2 spoke with P1 about any concerns with the condition of the VA or his/her bedroom.

- P1 thought the G, CM1, and CM2 were inside the facility for a meeting on April 17, 2025, to discuss the VA's hygiene concerns. However, the topic of the meeting changed to an unrelated issue so the VA's hygiene was not discussed. P1 did not think that the G, CM1, and CM2 were there at any point after to check on the condition of the VA's bedroom and/or the VA's hygiene.

P2 and P3 provided the following consistent information:

- The VA lived in another residential program run by the same license holder prior to moving into the facility and had a history of poor hygiene; refusing to shower, taking his/her medications, not wearing undergarments; and not accepting staff person prompts and/or assistance with the VA's hygiene, cleaning, and laundry.

- On April 17, 2025, a team meeting was held to discuss the VA's hygiene but during the meeting the focus shifted to an unrelated issue and concerns about the VA's hygiene were not discussed. P3 stated s/he made other attempts to speak with CM1, CM2, and the G about the VA's hygiene but each were "difficult" to reach and often did not respond to P3.

- Staff persons were to prompt the VA to shower and clean his/her bedroom and assist the VA if s/he allowed them to. In the past, the VA had been "racist and antagonistic" to staff persons, and staff persons, whose names P3 could not recall, told P3 that when they prompted the VA, the VA called them racial slurs, so they did not feel comfortable providing repeated prompts to the VA.

- The VA did not allow anyone in his/her bedroom, and staff persons needed to "respect" that choice, which made it difficult for the facility and staff persons to ensure cleanliness of the VA as well as his/her bedroom. P2 stated that one month prior to the VA moving from the facility, s/he told staff persons that they needed to start doing room checks because the VA and another unidentified resident were not cleaning up after themselves, and staff persons "needed to assist" them. P2 stated that the VA "absolutely refused" staff assistance.

- P3 stated that if staff persons were not successful in prompting the VA to clean his/her room or shower and it became a health or safety issue, it would be the responsibility of P1 to "step in" and help staff persons. P2 thought that staff persons could take the VA to the community and while s/he was gone, other staff persons could clean his/her bedroom. P2 stated staff persons could not "force [the VA] into the shower, or force [the VA] to wash [him/herself]."

- It was the expectation that P1 was at the facility every week, working with staff and "modeling" for them so s/he should have seen the condition of the VA's bedroom or smelled the odor. If staff persons told P1 that the VA was not letting them into his/her bedroom, P1 should have a conversation with P2 and P3 to

request help with the situation. P1 did not tell P3 that the VA refused to let staff persons into his/her bedroom.

- Neither P2 or P3 were aware of there being rodent droppings in the VA's bedroom and stated the facility regularly utilized a pest control agency to ensure there were no issues.

P4 provided the following information:

- The VA did not like to shower and/or clean up after him/herself and left food and dishes "all over the place." The VA's bedroom was "pretty gross" and "always smelled" because the VA did not shower, did not wipe properly after using the bathroom, and sat in his/her soiled clothing. The VA had an "I don't care" attitude and if staff persons tried to have the VA do anything, s/he would just say, "No."

- On an unknown date approximately two months before the VA moved out of the facility, P2 and P3 told staff persons that they needed to check the VA's bedroom for dishes and ensure the residents bedrooms were clean. Staff persons were also told to clean the VA's bedroom even if s/he "didn't like it." Some staff persons were not comfortable cleaning the VA's bedroom against his/her wishes because the VA swore at them and called them racial slurs.

- After the VA moved, P4 cleaned the VA's bedroom and noted a "pretty strong" smell of urine and feces. P4 thought the VA's bedroom smelled as such because the VA did not thoroughly clean him/herself after having a bowel movement and left stool stains "everywhere." P4 denied seeing mouse droppings in the VA's bedroom, but did not look closely because P4 was "sweeping and shoveling things into bags."

- The smell in the VA's bedroom was a problem the entire time the VA lived at the facility, and staff persons, residents, and residents' family members complained about the smell as well. P4 did not see mouse droppings when s/he cleaned, but did not look closely because s/he was "sweeping and shoveling" things into garbage bags.

P5 stated that the VA "did not care" to pick up after him/herself, had "really poor hygiene," and "refused" to shower or brush his/her teeth. It was not uncommon for the VA to smell like feces. Staff persons were responsible for providing cues to the VA so s/he would consider showering, but when the VA refused, staff persons "shrugged their shoulders" because it was the VA's choice not to shower. P5 did not notice an odor coming from the VA's bedroom, but when P5 worked, the VA usually slept on the couch in the basement, so P5 had no reason to go into the VA's bedroom. P5 had previous concerns with overall cleanliness at the facility and addressed these concerns with P1 multiple times. P5 thought that P1 "ghosted" him/her and did not care to address the concerns.

P6 stated the VA would not take showers when staff persons asked him/her to, "rolled" his/her eyes at staff persons, and just not do it. P6 thought the VA showered only when s/he was incontinent, or when CM2 was taking the VA into the community. It was the resident's responsibility to clean their bedrooms, but staff persons helped if the resident let them. Staff persons did not clean residents' bedrooms without their consent and needed to ask for permission to enter their bedroom to clean. If a resident refused, staff persons notified P1. If a resident agreed, staff persons then assisted them with cleaning. P6 cleaned the VA's bedroom on two occasions, once before the VA moved out of the facility, and once after the VA moved out. P6 stated that when the VA moved out,

there was trash and paper on the floor and P6 did not notice an odor in the VA's bedroom. P6 did not have previous concerns with the condition of the VA's bedroom

A document titled *Support Team Meeting Attendance/Meeting Minutes* showed that on April 17, 2025, P1, the G, CM1, and the VA attended the VA's semi-annual meeting. Agenda topics included the VA's finances, the VA's move into the facility, and the VA's unsupervised time. The notes stated that the VA was leaving dishes in his/her bedroom and refusing to take his/her medication. There was no additional information regarding the VA's hygiene or the cleanliness of the VA's bedroom included on the document.

According to www.pestabc.com mice "can carry a host of dangerous pathogens" and provided the following additional information (emphasis in original):

> Mice droppings can transmit disease to humans. Some rodents may carry bacteria, viruses, or parasites in their feces, which could cause illnesses if ingested or if the particles become airborne. It is advisable to take precautions when dealing with mice droppings, such as wearing gloves and a mask, and properly cleaning and disinfecting the affected areas.
>
> Mice are notorious carriers of various diseases and bacteria due to their foraging habits and unsanitary living conditions. Their presence in your home or workplace can pose significant health risks by contaminating surfaces and food sources. *One primary contamination source is through direct contact with mouse droppings or urine.* When mice roam freely within the premises, they leave behind trails of excrement that can contaminate countertops, cabinets, shelves, and food items if proper precautions are not taken. **Ingesting or touching these contaminated surfaces can lead to illness and infection.** Additionally, mice droppings can contribute to indoor air pollution. As they dry out over time, microscopic particles may become airborne and circulate within the indoor environment. Inhaling these particles can potentially lead to respiratory issues, allergies, or even more severe conditions for individuals with weakened immune systems.

The facility's training records showed that all staff persons who were interviewed were trained on the VA's plans and the Reporting of Maltreatment of Vulnerable Adults Act. One staff person who was not interviewed for this investigation, had not had training on the Reporting of Maltreatment of Vulnerable Adults Act annually as required which was a violation of Minnesota Statute, section 245A.65, subdivision 3. On August 4, 2025, the staff person completed the training.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245D.04, subdivision 3, paragraph (b), clauses (8) and (9) states in part that a person's protection related rights include the right to:

- a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects.
- a setting that is free from hazards that threaten a person's health or safety.

Minnesota Statutes, section 245D.22, subdivision 1, states in part that the license holder must maintain the interior of the buildings and structures including walls, floors, fixtures, equipment, and furnishings in good repair and in a sanitary and safe condition. The facility must be clean from accumulation of dirt, garbage, vermin, and

insects. The license holder must correct building and equipment deterioration, safety hazards, and unsanitary conditions.

Conclusion:

A. Maltreatment:

The VA moved into a residential program operated by the license holder on October 4, 2024, and then moved into the facility on January 29, 2025. When the VA moved into the facility, the VA had a history of poor hygiene and often refused to shower, clean him/herself after going to the bathroom, clean his/her bedroom or do laundry and the facility/staff persons were aware of the VA's history in these areas. On July 7, 2025, the VA moved out of the facility to a residential program operated by a different license holder.

CM1 stated that the VA was unable to take care of his/her own health and safety needs and required reminders and physical assistance with managing his/her medication, scheduling and attending appointments, and ensuring appropriate hygiene. The VA required placement in a facility due to the level of assistance s/he required with maintaining basic tasks. CM2 stated that the VA needed prompts and reminders for daily hygiene, had "no concept" of his/her basic needs, and was "very bad" with his/her hygiene. The last few times CM2 saw the VA, the VA's skin was "flaking," s/he had dandruff all over his/her clothes, and smelled "horrible." CM2 noticed that the VA's hygiene had been worse for three months prior to the VA moving. The VA's *Individual Abuse Prevention Plan* (IAPP) stated that the VA struggled with hygiene, went "several weeks" without showering, struggled with doing laundry and when the VA went to the bathroom, s/he did not wipe. Yet, despite the information from CM1 and CM2 and in the IAPP that the VA was at risk and need reminders and assistance with his/her hygiene, the IAPP specified that the VA was not susceptible for abuse in this area, and the facility did not list needed support from staff persons related to these issues.

CM1 and CM2 each stated that on July 7, 2025, when they arrived at the facility to help the VA move, the VA and the VA's bedroom had a "strong" odor and the condition of the VA's bedroom was "very bad." CM1 and CM2 provided consistent information that the VA bedroom had garbage, food, soiled clothing, and mouse droppings on the VA's dresser which was a violation of Minnesota Statutes, section 245D.04, subdivision 3, paragraph (b), clauses (8) and (9); and Minnesota Statutes, section 245D.22, subdivision 1. When the VA removed items from his/her dresser, the VA "pulled up" his/her shirt sleeve and "brushed" the droppings off with his/her arm.

CP1 and CP2 each stated that on July 7, 2025, when the VA arrived at the new residential program, the VA's clothing was covered/soaked in urine and feces, there were mouse droppings present in the VA's belongings, and both the VA's belongings and the VA had a strong odor. Due to the condition of the VA's belongings, 80-85% of the VA's belongings were thrown away. The VA told CP2 that while living at the facility, s/he "felt isolated," spent a lot of time in the basement "unattended," and s/he had not brushed his/her teeth in a month.

It was not known how long the conditions of the VA's bedroom persisted, however, staff persons at multiple levels of authority were aware of complaints by R1 and R2 regarding the VA's hygiene and were aware of the VA's history and provided information that the VA was not clean and had a significant odor to his/her person and from his/her bedroom. P3 stated s/he attempted to speak with CM1, CM2, and the G regarding these concerns, however CM1 and CM2 each stated they did not receive communication from the facility regarding concerns with the VA's hygiene and/or the condition of the VA's bedroom.

Although the VA was responsible for his/her cares independently and had a right to bathing and living how s/he preferred, that staff persons could not force the VA to shower or clean his/her bedroom, and that standards of cleanliness vary from person to person, the VA was receiving services in a licensed facility for which staff persons at multiple levels of authority were aware of the concerns and did not take action to ensure the VA lived in a setting that was free from hazards, including mouse droppings, that threatened the VA's health or safety. Given this and that the VA was allowed to live in a bedroom with human feces and urine and with mouse droppings on his/her dresser and clothing, there was a preponderance of the evidence that there was a failure or omission to supply the VA with reasonable and necessary care or services.

It was determined that 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).

B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):

> When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead agency shall consider at least the following mitigating factors:
>
> (1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;
>
> (2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and
>
> (3) whether the facility or individual followed professional standards in exercising professional judgment.

Although the VA could not be forced to shower, the facility had a responsibility to ensure the VA lived in an environment which was free from accumulation of dirt, garbage, vermin, and insects and free from hazards that threaten his/her safety. Given that staff persons at multiple levels of authority were aware of the condition of the VA's person and his/her bedroom, individual responsibility was mitigated, and the facility was responsible for the maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by a facility meets the statutory criteria to be determined as "serious."

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated neglect for which the facility was responsible did not meet statutory criteria to be determined as serious.

Action Taken by Facility:

The facility completed an internal review and found that policies and procedures were adequate and followed. The VA no longer lived at the facility.

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

On October 23, 2025, the license holder was ordered to forfeit a fine of $1000 as a result of the substantiated maltreatment for which the facility was responsible. The maltreatment determination and the Order to Forfeit a Fine are each subject to appeal.