

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: 202309838 and 202400979

Date Issued: November 6, 2025

Name and Address of Facility Investigated:

Enriched Living
14703 Dunbar Ct.
Apple Valley, MN 55124

Enriched Living
301 County Rd. 2 W.
New Brighton, MN 55112

Disposition: Substantiated as to emotional abuse, physical abuse, and neglect of a vulnerable adult by a staff person

Substantiated as to neglect of a vulnerable adult by a staff person.

License Number and Program Type:

1115681-H_CRS (Home and Community-Based Services-Community Residential Setting)
1086810-HCBS (Home and Community-Based Services)

Investigator(s):

Jason Pehler
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
jason.pehler@state.mn.us
651-431-4830

Suspected Maltreatment Reported:

It was reported that staff persons (SP1-SP9) engaged in physical abuse, emotional abuse, and neglect of a vulnerable adult (VA).

Date of Incident(s): Multiple incidents from November 17, 2023, to January 27, 2024

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); and subdivision 17, paragraph (a):

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.

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 January 18, 2024; from documentation at the facility; and through seventeen interviews conducted with the VA, facility supervisors P1-P3, the VA's case manager (CM), the VA's guardian (G), the VA's team member (TM), a mental health counselor who did not work for the facility (HMC), a medical professional (MP), SP1-4, and SP6-9. After reviewing the video recording it was determined SP5 interactions with the VA were minimal during the incidents and SP5 was not involved in the allegations, so SP5 was not interviewed.

Facility documentation showed the VA had many interests, but had difficulty staying motivated. The VA's baseline was different than other persons as s/he was always on edge, and had consistent thoughts of the hospital or leaving the facility unsupervised. The VA could maintain conversations regarding other topics, and enjoyed activities such as card games, watching television, and completing crafts. However, the VA could suddenly change and would not listen to staff persons' redirection. The VA was diagnosed with anti-social personality disorder, borderline personality disorder, schizoaffective disorder, disruptive mood dysregulation disorder, post-traumatic stress disorder, autism, depression, anxiety, and displayed symptoms that could be psychosis.

The VA has multiple *Rights Restrictions*:

- The VA was not able to have in-person communication with people s/he met online or in the community. Any visits with friends or family would be planned through a facility supervisor.
- The VA's personal possessions that posed a risk to the VA's health and safety were locked in the staff office, and the VA could request staff persons' assistance to use those items. Staff persons would supervise the VA while using the items and return the items to the locked area upon completion.
- The VA had an established time in which s/he could call his/her parents, and have family members visit the facility. The VA could call the CM or the G at any time of the day, but also had a scheduled phone call with the G once a week. Staff persons would get the facility phone from the staff office and dialed the phone number for the VA. The phone calls were made using the speaker phone function, and staff persons would hold the phone. If staff persons noticed the conversation become unsafe, staff persons

would prompt the VA to end the phone call, and encourage the VA to call the person back at a later time. The phone was to be returned to the staff office after the call was completed.

The VA's *Coordinated Service and Support Plan Addendum, Individual Abuse Prevention Plan, Self-Management Assessment, and Behavior Support Plan* provided the following information:

- The VA required two staff persons to provide supervision 24 hours a day, and did not have community unsupervised time. There were times that staff persons would not be within sight of the VA due to needing to complete required tasks at the facility, but staff would always be within auditory range of the VA. There were cameras at the facility due in part to the VA's history of making inaccurate accusations. All of the facility doors that led outside were locked at all times. Staff persons should prevent the VA from exiting the facility by physically blocking or "restrain[ing]" the VA if s/he showed "signs of dysregulation." If the VA left the facility without supervision staff persons should contact 9-1-1, and search for the VA.
- The VA engaged in verbal aggression, physical aggression, property destruction, leaving without supervision, and self-injurious behaviors (SIB) to gain control over his/her environment, as the behavior would receive a predictable reaction from those around the VA; or allow the VA to escape/avoid a situation or activity s/he was asked to participate in. The VA had difficulty communicating his/her thoughts and feelings verbally with individuals and instead engaged in behaviors as a means of communication. The VA could also have a difficult time understanding social cues and may misinterpret situations due to his/her mental health. The VA would also use negative behaviors to gain attention.
- The VA engaged in physical aggression and combative behaviors which included seeking revenge, suicidal gestures, rage, acting recklessly, and had previously attempted to bite staff persons. The VA's physical aggression resulted in frequent use of restraints and seclusion.
- The VA was susceptible to physical abuse, and had an inability to identify potentially dangerous situations, lacked community orientation skills, and engaged in inappropriate interactions with others. Furthermore, the VA had an inability to deal with verbally or physically aggressive persons, and the VA had a history of verbal and physical aggression toward others.
- The VA was susceptible to self-abuse, and staff persons needed to remain within close visual range of the VA while the VA was at the facility and in the community. When escalated, the VA might leave the facility without telling anyone, and the VA could have difficulty while staff persons redirected the VA back to the facility. Staff person should use *Crisis Prevention Intervention* skills if the VA placed him/herself in imminent danger. If there were safety concerns for the VA or staff persons, staff persons would contact 9-1-1. Staff persons could temporarily withhold or remove objects if the VA was using the object to hurt him/herself or others.
- The VA was not often aware of things that might be unsafe for him/her, and would escalate in vocalization and behavior when scared, upset, agitated or anxious. Staff persons would verbally redirect the VA to the closest and quietest area to encourage de-escalation. It was permitted to block or redirect the VA's limbs or body without holding or limiting his/her movement to interrupt a behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.

- All staff persons were trained on recognizing abuse, the facility's reporting procedures, and staff persons should try to stop the abuse and verbally/physically direct the VA to safety. The VA had a history of finding the "weakest link," whether it was a staff person or how a program plan was written.

The VA's *Positive Support Transition Plan* and *Crisis Protocol* provided the following information:

- The VA's "Targeted Interventions" stated the facility provided staff persons with eight hours of "Positive Supports Rule" training, and eight hours of *Crisis Intervention Training*. Staff persons were trained on the following Emergency Use of Manual Restraints (EUMR):
 - A one person standing one arm restraint: Staff person stood behind the individual grasping one forearm with both hands.
 - A one person standing two arm restraint: Staff person stood behind the individual grasping one forearm with both hands and their arm pinning the person's other arm to their body.
 - Two person standing restraint: One staff person stood on either side of the person, with their arms holding one of the person's arms at the armpit and the forearm, and staff's legs in front to prevent falling.
 - Two-person supine restraint: One staff person on either side of the person in supine position, using their hands to immobilize the person's arms and their own legs to immobilize the person's legs.
- The *Crisis Support Planning and Response* section, and the VA's *Crisis Protocol* provided examples and explanation of the VA's phases of behavior, antecedents, as well as strategies for staff to utilize when working with the VA:
 - The VA's "Phase 1" identified the VA as ideal/calm, and described the VA as engaged and interacting with other persons, the VA would be laughing, smiling. The VA would want to listen to music, watch television, sit on the couch, dance, and engage in community activities. Staff persons would engage with the VA, participate in activities with the VA, use the VA's pre-made schedule, and utilize scheduled "coping breaks."
 - The VA's "Phase 2" and "moderate escalation" included increased pacing, getting louder, yelling, increased swearing, demanding statements, slamming doors, posturing, and making threats of SIB or physical aggression. Phase 2 section included the VA's antecedents/triggers, and how staff persons should support the VA.
 - The VA's "Phase 3" and "escalation" included behaviors such as verbal and physical aggression. The VA may also use intimidating behaviors such as getting close to someone's face, towering over them, rapid breathing, inaudible speaking, constant screaming, and SIB. If the VA placed him/herself or others in imminent physical harm, staff persons would refer to the facility's EUMR Policy in order to keep the VA safe. De-escalation strategies and interventions were provided in the document. During the time the VA was escalated staff persons should monitor body positioning, facial expressions, and manage personal boundaries, emotions, and affect. Staff persons should also encourage the VA to

use coping skills and validate the VA's feelings. Staff persons should avoid touching the VA's property, threatening to take things away, speaking negatively, stating the VA needed to "act right," or ignoring the VA.

- The VA's "Phase 4" described the VA's recovery of being in crisis as; the VA being tired, fearful, or hungry. Staff persons would support the VA by offering to sit and talk with the VA, providing validation, or redirect the VA to watch television, listen to music or to eat food. Staff persons could also offer the VA a weighted blanket. Staff persons should avoid talking about the recent behavior until the VA was ready, or discuss what was taken away from the VA, or what s/he did not earn. Furthermore, staff persons should not talk about past behaviors or that staff persons did not want to work with the VA.

The facility was a single level home, and the VA was the only person residing at and receiving services from the facility. Upon entering the facility there was a kitchen to the right of the main entry way and a short hallway straight ahead which led to a hallway. The hallway split in two directions, to the living room, and the other direction was to the staff office, the VA's bedroom, and a bathroom, as well as a second bedroom. There were two cameras located within the facility, per request of the VA's team. One camera recorded the hallway near the staff office, but there was not a view inside the VA's bedroom. The second camera provided a view of the living room and a portion of the kitchen.

In November 2023, DHS received information that an alleged incident of maltreatment occurred. From December 2023 to January 2024, there were additional reports of alleged maltreatment. During the investigation nine video recordings from facility camera were reviewed. The date range of the recordings were from November 17, 2023, to January 27, 2024.

Regarding an incident on November 17, 2023:

It was reported that on November 17, 2023, SP1 held the VA's right arm and caused "intense" bruising on the VA's right arm. Additionally, it was reported that while in the VA's bedroom SP1 broke the VA's wrist brace, pinched the VA's arm, threw the VA's head against the wall, pulled the VA's hair, and punched the VA in the head.

There were two photos provided related to this incident:

- The first photo showed an irregular shaped bruise that was approximately an inch length and width, and appeared to be similar to a square shape. The bruise was located on the VA's abdominal side.
- The second photo was of the VA's left shoulder/bicep. There were multiple quarter to half dollar sized bruises which were purple/brown. It was alleged that the bruises appeared to be consistent with the shape of fingers of a hand.

The MHC said the VA showed the MHC bruises on his/her left arm, an abrasion on his/her left wrist, and a cut on his/her fingertip. The MHC believed the injury to the left arm was consistent with finger marks, and the abrasion on his/her right wrist was consistent with the VA's arm brace being pulled off. The VA showed the MHC the cut on his/her fingertip which the VA said was a result of SP2's ring. The MHC said the VA had a history of getting injured in the process of staff persons trying to calm the VA.

There were two video recordings from different angles/locations in the home that captured the incident, and each recording had overlap during the incident. The information below was a combination of the two recordings from November 17, 2023:

- At 11:03 a.m., the VA requested to use the telephone, and wanted to contact the G. The VA said, "You can't restrict" his/her use of the phone. SP1 handed the telephone to SP2 while the VA was next to SP2. The VA moved toward SP2, to which SP1 stated the VA was fighting for the phone, and SP2 handed SP1 the phone. SP1 told the VA a staff person had to call the person for the VA, and handed the phone back to SP2. The VA and SP2 moved out of the video recording view, but could be heard making noise, and SP1 moved toward them and said, "Stop fighting." The VA started yelling loudly and SP1 said, "Stop." SP1 and SP2 moved back into camera view and toward the staff office, and the VA moved toward SP2. SP2 and the VA engaged in physical contact which included SP2 blocking the VA from entering the staff office, the VA spat at SP2, and the VA walked away thereafter. The VA could be heard yelling out of camera view.
- At 11:07 a.m., the VA moved toward the staff office and appeared to sit down in the doorway of the office. The VA scooted on the floor toward SP2, who was in the hallway, and the VA made physical contact with SP2's leg and wrapped his/her legs around SP2's leg. SP2 requested the VA to stop, however the VA said, "No."
- At 11:08 a.m., SP1 came out of the staff office and moved toward SP2 and the VA. SP1 and SP2 moved in front of the VA's bedroom, and the VA yelled about his/her foot, however SP1 and SP2 did not appear to be touching the VA's foot. SP2 tried to assist the VA off the floor, however the VA resisted, and moved a few feet down the hallway. Thereafter, the VA engaged in physical aggression toward SP1 which included attempting to bite SP1's leg, and the VA repeatedly hit SP1's leg while stating "move." The VA continued to yell for the phone, and engaged in physical aggression toward SP1.
- At 11:12 a.m., SP2 removed the VA's glasses, as the VA continued to physically aggress towards SP1. Thereafter the VA got up off the floor, and attempted to go into the staff office, however SP2 moved into the doorway. The VA said s/he wanted his/her glasses, however SP2 said s/he did not want the VA to break his/her glasses.
- At 11:13 a.m., the VA slapped SP1 in the face, and SP1 moved his/her hands to the VA's arm and physically moved the VA out of the hallway camera view. SP1 and the VA moved into the living room as seen on the living room camera view. SP1 held the VA's left arm, and moved the VA toward the living room while maintain a grip on the VA's left arm. SP1 guided the VA to a living room couch, and let go of the VA once they were near the couch. The VA continued to yell and looked and touched his/her arm as SP1 walked away.
- At 11:14 a.m., SP2 moved toward the dinner table and sat down. The VA got up from the couch and moved out of the recording view, and the VA could be heard yelling, and requested the phone. SP2 followed the VA, and briefly re-appeared in the living room with a pair of glasses that s/he put on the couch.
- At 11:15 a.m., SP2 and the VA re-entered the living room, with SP2 walking behind the VA. The recording showed SP2 maintain some physical contact with the VA, but due to the angle of the recording it was

unclear if SP2 was holding the VA's hand, wrist, or other part of the VA's body. SP2 disengaged the physical contact, and walked out of camera view. The VA continued yelling and turned around and followed SP2 out of the camera view down the hallway. A staff person (unknown staff) requested the VA "Stop."

- At 11:16 a.m., the VA returned to the living room, obtained a pair of glasses, and walked out of camera view down the hallway. The VA started yelling, and SP1 physically moved the VA into the living room while holding the VA's wrist. SP2 came into camera view and assisted SP1 in moving the VA. The VA was moved backwards into the living room, and the VA appeared to go limp and sit/fall to the living room floor. SP1 and SP2 continued to complete an EUMR on the VA with SP1 on the VA's right side, and controlling of the VA's right arm, and SP2 controlled of the VA's left arm. During the restraint SP2 told the VA s/he needed to "relax now," and the VA continued to yell "it hurts" as the video ended.

SP1 denied attempting to harm the VA, however after watching the video recording said the VA's bruise on his/her left bicep/shoulder may have occurred while SP1 moved the VA from the hallway to the couch. SP1 said s/he held the VA's arm due to the VA's physical aggression and behavior toward him/herself and SP2.

SP2 said s/he attempted to work with the VA during the incident, however the VA continued to have behaviors toward him/herself and SP1. SP2 was not aware of any injuries to the VA from the incident. SP2 said during the incident s/he had tried to block the VA from going into the staff office, and the VA's bedroom, as the VA would leave the facility via his/her bedroom window when s/he was escalated.

The MP said the VA was "regularly" at the emergency room and had a history of SIB, and "historically" had bruising that the VA said was from staff persons. However, the MP said the bruising was "often" from SIB.

SP1 and SP2 completed an *Incident Report* and *EUMR Form* regarding the incident on November 17, 2024, which provided the following information:

- The VA had behaviors which included kicking, fighting, and spitting on staff persons. The VA also engaged in SIB, and the VA was placed into a EUMR. Staff persons tried to use verbal de-escalation to get the VA to baseline behavior, and provide the VA his/her medications, however the VA continued to engage in behaviors. There were two documented restraints, and it was documented the restraints lasted less than one minute.
- The VA de-escalated once staff shift changed occurred at the facility.

Regarding an incident on November 30, 2023:

It was reported that on November 30, 2023, SP3 and SP4 were working with the VA, and taunted, criticized, and laughed at the VA, called the VA names, "got in [the VA's] face," and put the VA in unnecessary restraints.

A video which was approximately 47 minutes provided the following:

- The recording started at 7:35 a.m., on November 30, 2023. During the first six minutes of the recording the VA's voice could be heard as s/he appeared to have escalated multiple times, and SP3 and SP4 could

be heard speaking to the VA in a normal tone. The VA stated, "Get off me," and SP4 said, "You just bit me," and SP3 or SP4 said, "No one is on your foot." SP3-SP4 engaged in a back-and-forth verbal interaction with the VA, which included statements regarding interactions the VA had in the previous days. The VA engaged in verbal aggression including name calling and racial slurs toward SP3 and SP4. The VA went to his/her bedroom at the 4:15 minute mark of the video, and SP3 checked on the VA in his/her bedroom at the 4:45 minute mark and left the bedroom immediately. Thereafter the VA told SP3 to "stay out" of his/her bedroom.

- At the 5:00 minute mark of the video SP3-SP4 went into the VA's bedroom, and it appeared SP4 was pushed out of the VA's room, and then attempted to re-open the door. A loud slapping or hitting sound was audible, but the recording did not show what or how the sound was made. SP4 could be heard stating, "We talked about this," and "We are not doing it." The VA started screaming about being hurt, and requested staff persons "get off" him/her. Again, there was no visual of what was occurring in the VA's bedroom, however SP4's voice was escalated. The VA stated, "Let me go," to which SP3 replied, "Stop hitting us," and "We only do holds if you hit." SP3 addressed the camera at 7:44 a.m., and stated the VA was "lying," and added "people are not going to want to work with you, I will not work with you if you lie." SP3 asked the VA why s/he was "acting like this," and both SP3-SP4 made additional statements about the VA lying and being a "liar."
- Around the 15-minute mark of the recording the VA, SP3, and SP4 walked out of VA's bedroom, and the VA tried to open the staff office door. SP4 placed his/her hands on the VA's shoulders/arms and attempted to guide the VA away from the staff office door. Thereafter, SP4 moved in front of the staff office door and blocked the VA from the staff office. The VA pushed his/her arm into SP4's face, and SP3-SP4 attempted to hold the VA's wrists for ten to fifteen seconds, however the VA pushed SP3 and SP4 away. During the interaction the VA and SP4 raised their voices, and SP4 pointed a finger directly into the VA's face. After the interaction ended the VA walked toward his/her bedroom. SP3-SP4 followed the VA, and SP4 stated, "Are you serious? Are you actually serious? We can do this all day." The VA, SP3, and SP4 entered the VA's bedroom at 7:51 a.m. At 7:52 a.m., an alarm sounded, and the VA, SP3, and SP4 returned to the hallway. The alarm remained on until 7:55 a.m. Thereafter SP5 arrived at the facility and attempted to interact with the VA. While interacting with SP5 the VA became escalated at SP3 and started yelling. SP4 requested the VA to move in "ten seconds," and told the VA to "move away" from the staff office door. SP4 continued to have an animated conversation with the VA during the time the VA was in front of the staff office door before walking away from the staff office at 7:58 a.m.
- Around the 23-minute mark the VA, SP3, and SP4 were not in the camera view, but the VA was heard saying, "Get off me," and SP4 stated, "Don't bite [him/her]." SP4 stated, "Keep doing it," and "We will go to the ground." The VA yelled, "Get off me," and SP4 said, "You are literally trying to scratch me." SP3-SP4 continued to engage verbally with the VA while the VA was screaming. SP4 threatened to take the VA to the floor if s/he continued to engage in the behavior. The VA repeatedly said, "Get off me," and SP4 stated, "Act your age," and called the VA a liar.
- The VA returned to the hallway around the 28:30-minute mark and tried to open the staff office door. SP3 and SP4 followed the VA, and SP4 moved in front of the VA. The VA screamed in SP4's face and proceeded to touch his/her own lips while leaning toward SP4. SP4 and SP3 grabbed the VA's wrists, and SP4 stated, "We are doing this," after grabbing onto the VA's wrist, and SP3 said, "You are gross and that

is nasty.” While being held by SP3, the VA attempted to bite SP3 and was able to get out of the wrist restraint by SP3 and was able to get ahold of SP3’s shirt and hair. SP3 continued to try and regain control of the VA’s hand/wrist, while the VA was moving, and attempting to bite SP3. SP4 laughed while making a comment about the VA being hungry, and s/he should eat some food.

- At the 30:10-minute mark SP4 released the VA’s wrist, however SP3 continued to try and restrain the VA’s wrist/hands until the VA stated SP3 scratched him/her. SP3 responded by stating, s/he did not have nails.
- SP5 left the staff office at the 30:47-minute mark, and the VA was blocking the hallway. SP5 tried to talk with the VA about the situation, and then attempted to move past the VA in the hallway. SP3-SP4 engaged in physical contact with the VA and attempted to hold and control the VA’s wrist/arms in an attempt to allow SP5 to leave the facility, however the VA continued to block the hallway. SP5 tried to move past the VA, but the VA wrapped his/her arms around SP5, but SP5 was able to get out of the VA’s grasp briefly, but the VA grabbed SP5’s sweatshirt hood. SP3-SP4 attempted to get between the VA and SP5, and SP5 was able to slip out of the VA’s grasp and left the facility. Thereafter, the VA grabbed SP3 by the hair, and after the VA let go of SP3’s hair, SP4 said, “Grab [the VA],” and the VA’s wrist were held by SP3-SP4 before the VA sat down onto the floor. While sitting on the floor, the VA spat on SP3, to which SP3 made additional comments about the VA being “gross.” While on the floor the VA screamed, “I can’t breathe,” and said his/her wrists hurt. The VA used multiple derogatory terms toward SP3-SP4 and threatened to harm SP3-SP4 during the incident.
- SP6 arrived at the facility around the 38:30-minute mark. Prior to SP6’s arrival, the VA was not struggling to talk, and there was no apparent concern about the VA being unable to breathe. Upon SP6 opening the front door, the VA immediately escalated and said s/he could not breathe. SP6 entered the facility and came into the camera view around the 39-minute mark and said, “Why? What is your problem?” to the VA, and continued to say, “You don’t control nothing.” The VA called SP6 a name, and the VA continued yelling in another room (no visual). SP3 left the facility and the VA, SP4, and SP6 continued to have escalated verbal interactions, including the VA yelling, and standing in front of the staff office door, which blocked SP6 from entering the staff office. SP4 used his/her body (shoulder/hand) and moved the VA approximately three feet so that the VA was not physically blocking the staff office door and SP6 entered the staff office. The VA moved down the hallway out of camera view and continued screaming before eventually going to his/her bedroom.

Regarding an incident on December 26, 2023, at 3:30 p.m.:

A video which was approximately two minutes long provided the following:

- The VA slowly slid a chair from the dining table across the living room. While the VA was sliding the chair, SP6 walked past the VA, and stood in front of the VA near a wall. The VA continued to move toward SP6, and the VA pushed the chair into SP6’s leg. The VA said, “Move!” to which the SP6 responded, “You are the only one that is stupid.” Thereafter, SP6 and SP7 made comments regarding the VA being “dizzy,” and SP6 continued to say the VA may not be able to complete activities for the following day due to the VA’s behavior. The VA responded by calling SP6 a “cunt,” and SP6 replied by saying, “No, you are being the cunt.”

- After the interaction with SP6, the VA walked back across the living room and into SP7, and SP7 requested the VA sit down. The VA walked directly into SP7, and SP7 responded by using his/her chest/shoulder to keep the VA in front of him/her. SP7 continued to provide the VA with directives to sit down and said, "You are dizzy," before the VA walked toward the hallway and out of the camera view.

Regarding an incident on December 26, 2023, at 4:10 p.m.:

SP6, SP8, and SP9 were working with the VA. It was reported that the VA was pushed onto a couch and physically restrained.

A video recording of the incident which was approximately five minutes provided the following:

- As the recording started SP6, SP8, and SP9, were near a dining table when the VA came up from behind SP6 and initiated physical contact with SP6. The VA touched SP6's arm, and then wrapped his/her arms around SP6's waist while standing behind SP6. It appeared the physical contact occurred due to a dispute over a container of popcorn. SP9 intervened by touching the VA's hands, and the VA redirected his/her attention to SP9. SP9 responded by pointing his/her fingers in the VA's face, and said something to the VA, however, the statement was not audible. SP9 then disengaged with the VA, and walked into the kitchen. The VA returned his/her attention to SP6 briefly, however once SP9 returned to the dining table the VA moved toward SP9, and SP9 walked into the kitchen, and around the hallway.
- SP9 reappeared into the camera view as s/he walked back into the living room area from the hallway. SP6 followed the VA to an area that was not on the recording, but at the 0:52 mark of the video the VA yelled inaudibly, and then stated, "Get off me." SP6 could be heard instructing the VA to not touch the door, and the VA moved back toward SP9 who was standing near the dining table. SP6 followed the VA, and stepped between the VA and SP9. SP6's used his/her shoulder to physical move the VA slightly and SP9 walked away from the VA. SP9 moved into the living room and sat down on the couch. The VA moved from the area near the dining table toward the couch, and SP6 again stepped between the VA and SP9. As the VA neared the couch, SP9 stood up, and SP6 used his/her shoulder to push the VA onto the couch, and said, "Sit down." The VA attempted to stand back up, but SP6 used his/her left arm to push the VA in the chest, and back onto the couch. The VA again attempted to stand up, and grabbed onto SP6, who fell toward the couch with the VA. SP6's right elbow/forearm landed near the VA's neck/chest. After SP6 and the VA were on the couch SP8 moved from the dining table to the living room. While on the couch SP6's back was toward the camera, however it appeared SP6 was holding the VA's wrists, while the VA started to yell, "Ow!" SP8 then grabbed ahold of the VA's right arm/wrist, and the VA continued to yell, however the VA was able to hit SP6 in the face with his/her left hand. SP6 responded and said, "You ever hit me in my...," however the remainder of the statement was inaudible as the VA started to yell. At the 2:12 minute mark of the video SP6 and SP8 attempted to disengage with the VA, and both stood up from the couch. The VA also attempted to stand up, but SP6 moved back toward the VA, and SP6 used his/her arms/shoulders to push the VA in the chest and the VA fell back onto the couch. SP6 went onto the couch with the VA and placed his/her body weight on the VA, before sitting next to the VA. While sitting next to the VA it appeared SP6 held onto the VA's wrist. Although based on the video it was unable to be determined exactly how SP6 was holding the VA. During the interaction the VA raised his/her hand to hit SP6, and the VA screamed while attempting to bite SP6. At the 2:22 minute mark of the video, SP6's right forearm appeared to be applying pressure on the VA's upper chest/throat for three seconds before SP9

used his/her hand to move SP6 off of the VA slightly. SP6 remained next to the VA on the couch, with the VA screaming, and SP9 stated, "You have to stop hitting people," and "Stop it." The VA then raised his/her hand and SP6 and SP8 reengaged in holding the VA. Around the 3:00 minute mark of the video the VA attempted to bite SP6, and SP8 placed his/her hand on the VA's forehead. The VA screamed multiple times, and requested SP8 to remove his/her hand from the VA's forehead. SP8's moved his/her hand from the VA's head at the 3:23 minute mark, and SP8 repeatedly told the VA not to bite. Based on the video it did not appear SP8 used significant pressure on the VA's head, or cause the VA to strain his/her neck. However, it was clear SP8 minimized the VA's ability to move his/her neck with his/her hand.

- Around the 3:31 minute mark SP6 and SP8 let go of the VA, and SP8, and SP9 moved away from the VA slightly, while SP6 remained next to the VA after they stood up from the couch. The VA and SP6 stood face to face for about twenty seconds, while SP8 and SP9 walked away. The VA turned toward SP9, and followed him/her to the dining table, and the VA slapped SP9's shoulder. SP9 turned around, and walked toward the VA, who retreated toward the couch. SP9 told the VA, "Don't touch me," multiple times before saying, "You remember [a previous staff members name] right." The VA continued to make statements toward SP9, who walked back toward the dining table, before the video ended.

The facility's *Internal Review* provided the following information:

- During the incident SP6 repeatedly pushed the VA on to the couch, and restrained the VA. During the interaction SP6's hands were not visible, but the VA seemed to be in pain. During the video SP6 was observed to have used his/her forearm and pushed it onto the VA's neck. The VA attempted to bite SP6, and SP8 held the VA head to prevent the VA from biting SP6.
- The facility determined SP6 and SP8 did not follow the facility's EUMR policy, and the training provided.
- During the incident SP9 was completing a training shift and did not participate with the physical contact with the VA. The facility also noted that SP9's interactions with the VA were not "appropriate" as s/he engaged in power struggles, threats, and aggressive posturing with the VA, all of which contributed to the escalation of the incident.

Regarding an incident on December 26, 2023, at 6:05 p.m.:

It was reported that SP6, SP8, and SP9 were working with the VA at the facility, and the VA was denied access to the phone.

A video recording of the incident which was approximately ten minutes long provided the following:

- The video showed SP6 had a conversation with the VA, which included the VA using racial slurs, and calling SP6 stupid. The VA requested to use the facility phone or computer, however, SP6 stated the VA was escalated. The VA disagreed that s/he was having a behavior.

- There was no other information obtained that showed maltreatment occurred during the interaction.

Regarding an incident on December 30, 2023, at 6:47 p.m.:

It was reported that SP6 and SP8 were working with the VA, and used a previous staff person's name to taunt the VA, made disrespectful comments toward the VA, and had physical contact with the VA.

A video recording from December 30, 2023, showed the following:

- The video showed SP6, SP8, and the VA were engaged in a verbal interaction, before moving to the hallway near the VA's bedroom where SP8 blocked the VA's access to his/her bedroom. The VA stated a previous staff person's name, and added that if SP6 and SP8 "beat" up the VA they would go to jail. SP6 and SP8 both stated the VA was scared of the previous staff person, and SP8 "laughed" after making the comments. The VA moved in front of SP8, and SP8 closed the VA's bedroom door. During the interaction the VA moved laterally, and the VA and SP8 had physical contact that was chest to chest. The VA pushed SP8 in the chest, and SP8 said, "Don't put your hands on me," and grabbed ahold of the VA wrists. SP6 was next to SP8, but did not engage in physical contact with the VA. The VA requested SP8 take his/her hands off of the VA, and responded by stating, "Don't touch me." The VA then threatened to spit on SP8, and SP8 let go of the VA's wrist. The VA immediately raised his/her hand, displaying the ability to hit SP8, but the VA did not hit SP8.
- SP6, SP8, and the VA continued to have a verbal interaction, and the VA got into SP6's face, and made what appeared to be mocking statements, before retreating toward the kitchen. The VA attempted to move back toward the bedroom, but SP8 moved back in front of the VA, preventing him/her from advancing down the hallway. At 6:51 p.m., SP8 postured him/herself at the opening of the hallway, with both arms extended to the wall. The VA pushed his/her body onto SP8's body, and SP8 stated, "Don't you dare touch me." The VA stated, "Then move," before screaming into SP8's face. SP8 moved a few feet down the hallway, before the VA touched SP8's body. The recording did not show where on SP8's body the VA touched, however SP8 had an immediately physical response. SP6 saw the VA touch SP8 and said, "What is wrong with you?" SP6 continued to say, "That is why you are losing staff."
- SP8 moved further down the hallway and stood in front of the VA's bedroom door. SP6 made a comment that was not fully audible, but contained the word "raped." The VA appeared to touch SP8 again, and SP6 asked the VA why s/he was touching SP8, and SP6 added the VA was "sexually assaulting someone." The VA redirected his/her attention to SP8, and screamed directly in SP8's face, while SP8 remained in front of the VA's bedroom. The VA continued to touch SP8, and SP6 made multiple statements that the VA "sexually assaulted" someone. SP8 responded to the VA's yelling by calling the VA "disgusting," and told the VA to not touch him/her. The VA and SP6 then engaged in a verbal interaction which included the VA leaning in toward SP6, and SP6 stating "Keep your fucking mouth away from mine." The VA proceeded to tap SP6's chest, to which SP6 then called the VA a "rapist," and said the VA was "sexually assaulting."
- The VA moved back toward SP8 and touched SP8 sweatshirt, before screaming in SP8's face telling SP8 to move because SP8 was in the VA's bedroom doorway. SP8 raised his/her voice and stated, "You don't need to sleep in your damn room." The VA responded by screaming in SP8's face that it was his/her room. SP8 screamed (not audible, too loud to understand) directly into the VA's face. The VA responded

by pushing SP8's face/head into the door. The VA told SP8 to get out of the house and that SP8 could not scream like that at the VA. SP8 responded by screaming, "Yes, I can," into the VA's face. The VA slapped SP8 in the face again, and SP8 told the VA if s/he touched him/her again, the VA was going to "the floor." SP8 added, "I will not get up," before mockingly screaming at the VA. SP6 and SP8 discussed contacting law enforcement due to the interaction with the VA before SP6, SP8, and the VA left the hallway, and the video ended.

Regarding an incident on January 4, 2024, at 5:45 p.m.:

It was reported that SP2 and SP8 were working at the facility with the VA and denied the VA access to the facility phone.

A video recording which was approximately nine minutes provided the following:

- Video recording showed the VA was laying on the couch and SP2 attempted to engage with the VA, however the VA appeared agitated. The VA requested to use the facility telephone, however SP2 did not respond to the VA. The VA raised his/her voice, calling out SP2's name, and hit the living room wall multiple times causing a loud pounding noise. The VA continued to demand SP2 get the phone. SP2 was heard stating the VA was engaging in a behavior based on his/her training, which the VA disagreed.
- At 5:48 p.m., SP8 was heard speaking with the VA, and SP8 and SP2 appeared to engage with the VA in a power struggle. SP8 continued to state that the VA makes "false accusations." SP2 and SP8 disengaged with the VA, for a short period of time, but SP2 and SP8 moved back into the living room, and the VA made multiple comments about SP2 and SP8's personal life. SP8 stated that they do not "lie" like the VA.

Regarding an incident on January 27, 2024, at 12:45 p.m.:

SP2 and SP8 were working at the facility with the VA. An additional unknown staff person was present as s/he was training at the facility. During the alleged incident SP2 and SP8 were working with the VA, and the VA was placed into a restraint by SP2.

A video from January 27, 2024, which was approximately five minutes provided the following:

- The video recording showed the VA walked quickly from the dining table area, across the living room, and slapped SP8's butt. SP8 attempted to walk away from the VA, but the VA slapped SP8's butt again, and the VA continued to try and slap SP8's butt multiple times while SP8 walked across the living room toward the dining table. SP8 moved a chair between him/herself and the VA, and the VA attempted to touch SP8's chest, before SP8 asked the VA to take a seat. The VA responded by spitting at SP8, and continued to threaten physical harm to SP8. SP8 appeared to remain calm and attempted to talk with the VA before moving toward the kitchen. During the interaction SP8 placed a chair between him/herself and the VA. The VA responded by attempting to grab SP8's shirt, and SP8 tried to move the VA's hand away from his/her shirt. The chair tipped over as SP8 retreated further into the kitchen, and SP8 and the VA moved out of camera view. At that time SP2 moved from living room towards kitchen area. It appeared the VA continued to initiate physical contact with SP8 while in the kitchen, however the camera angle did not fully capture the interaction between the VA and SP8.

- The VA and SP8 came back into camera view and SP8 was holding the VA's wrists. SP8 let go of the VA's wrists, and SP8 requested the VA to "Stop," and the VA positioned him/herself in front of SP8. SP2 moved into the kitchen, and out of camera view, and SP8 asked the VA, "Why are you turning on the oven?" The VA could be heard saying "ow" repeatedly, and shortly thereafter SP2 and the VA went around the hallway corner. SP2 was behind the VA, with one of his/her hand appearing to be on the VA lower back, and other hand potentially on the VA's hand/wrist. The VA abruptly fell onto the floor near the couch in the living room, and SP2 backed away from the VA, and observed the VA while standing near a wall by the kitchen. The VA made loud crying sounds, while SP2 asked if the VA wanted to "burn down the house." The VA stated, "It fucking hurts," and continued to make crying sounds. SP8 stated, "I don't want you turning on the oven," and "oven, stove, whatever."
- SP2 appeared to remain clam, while standing approximately five feet from the VA, and attempted to explain the VA's actions could "burn down the house," and "did not want that." The VA responded by getting up off the floor and running to the door in the living room. SP8 followed the VA, and intervened, and moved the VA away from door, before standing in front of the door as the VA remained in the living room and sat down on the couch. The VA continued making crying noises, and started to take off his/her pants. SP2 made a comment the VA was taking off his/her pants, and SP8 responded, "Let [him/her]. The VA started to pick or fidget with something on his/her abdominal prior to the recording ending.

The TM, the G, and the CM provided information which was consistent with the above videos, and the VA's client specific plans.

The VA was interviewed as part of the investigation, and provided general information that supported the allegations and treatment of staff persons as observed in the video recording.

Individual interviews were completed with SP1-SP4, and SP6-SP9. During the interviews each staff person was provided an opportunity to watch the above videos that they were specifically involved. Within the interviews this investigator reviewed each staff persons interactions with the VA. During those interviews there was consistent information regarding the difficulty of working with the VA due to his/her behaviors (as stated in client specific information). Additionally, staff persons acknowledged their interactions with the VA, and stated the VA was escalated during the recordings.

SP6 provided the following information:

- Prior to observing the video recordings SP6 said s/he had requested to be moved to a different facility prior to the alleged incidents. SP6 said while working at the facility s/he reviewed "some" of the VA's plans, but not all of them. SP6 said s/he completed training on EUMR during new employee orientation, and said s/he did not believe excessive force was used while restraints were completed, however, due to the size of the VA the SP felt it was "hard" to complete restraints.
- SP6 said there were inconsistent instructions regarding how often the VA could use the phone, and staff persons would try to use their best judgement to reduce the VA from calling crisis lines or supervisors when the VA was escalated.

- SP6 said during the video recordings s/he did not do everything correctly, and at times was “overwhelmed,” and “frustrated” due to the VA’s behaviors. SP6 also said s/he should not have engaged with the VA in the verbal back and forth during the video recordings.
- SP6 said during the one of the incidents the VA was triggered by SP9’s appearance. SP6 added that when the VA stood up from the couch during the interaction which included physical contact s/he believed the VA was going to “come” after SP6, SP8, and SP9. SP6 said during the interaction s/he never put his/her full arm on the VA, and did not try to hurt the VA. SP6 said that after watching the videos s/he realized that s/he should not have assumed what the VA’s action would be, but rather allow the VA to do whatever s/he was going to do. The SP6 added that s/he would not restrain the VA unless s/he was attempting to attack another person.
- SP6 said s/he said the VA was sexually assaulting him/her as the VA was touching SP6’s body parts.

SP8 provided the following information:

- Prior to watching the video recording SP8 denied using the previous staff person’s name. SP8 also said the VA tried to intimidate staff persons and often targeted females. SP8 denied physically abusing the VA, and said the VA had engaged in physical aggression toward staff persons, including SP8.
- After watching the video SP8 said the verbal interactions with the VA within the video recordings were not attempts to deescalate the VA, and admitted s/he had raised his/her voice multiple times. SP8 added s/he lost her temper, and was disgusted with him/herself.
- SP8 said the restraints that were in the video recordings, specifically the restraint SP6 engaged in on the couch, was not trained by the facility. SP8 said during that restraint, SP8 restrained the VA head reducing the VA’s ability to move his/her head in part because the VA had bitten SP8 in the past.
- SP8 said the staff persons, including him/herself, tried to use their best judgement to when the VA could use the phone if s/he was having a behavior.

The facility completed multiple *Internal Reviews* regarding the above incidents, as they reviewed the recordings. The facility took action and made the following changes:

- Increase the presence of on-site management within the facility and weekly check-in at the facility by administration. Video monitoring for reported incidents, as well as weekly “spot checks.”
- An Improvement Plan for the facility was developed on January 17, 2024. Bi-weekly meetings were implemented with the VA’s team to support the VA.
- SP1 did not work with the VA after December 5, 2023.
- SP2’s was no longer employed with the facility as of February 1, 2024, due to “subsequent incidents.”
- SP3 was provided a “final written warning” and later resigned as an employee.
- SP4’s was no longer employed with the facility as of January 25, 2024, due to “different reasons” that occurred before the facility became aware of the incident described above.
- SP6 did not cooperate with the facility’s investigation and no longer worked at the facility as of January 11, 2024.

- SP7 resigned from the facility prior to the facility being aware of the allegation.
- SP8 was provided a “final written warning” and thereafter no longer worked for the facility after February 6, 2024.
- SP9 received a final written warning and continued to work at the facility.

Law Enforcement was contacted during the investigation; however, did not complete a criminal investigation related to the above incidents.

P3 provided the following information:

- P3 said all staff persons that worked at the facility were provided training in positive supports, crisis intervention and EUMR before working to the facility. However, for a period of time the facility utilized a different organization to complete the required trainings as the facility was unable to complete the training internally. P3 said there was not a *Crisis Plan* for the VA that was developed until after the alleged incidents, and the facility and the VA’s team members worked together to create the *Crisis Plan*. P3 said all of the staff persons that worked at the facility had a minimal requirement of ten years of experience in the human services field.
- P3 believed there was a “culture shift” at the VA’s facility, and described it as “bullying” the VA. P3 said the culture change was “led by” SP6 and SP8, and P3 had never seen such a culture change at a facility before. P3 said the facility took steps to prevent further incidents from happening again. P3 reviewed all of the videos, but stated there was a delay in the facilities administration becoming aware of all of the alleged incidents, and administration only learned of all of the incidents due to this investigator’s communication.
- P3 explained that in the fall of 2023 the facility had multiple changes to the supervisors and administration teams that oversaw the facility. Furthermore, P3 said there was frequent turnover of direct care staff at the facility, as the facility had lost at least 27 staff persons since June 2023. Additionally, staff persons informed administration that they did not want to work with the VA, due in part to the VA’s behaviors could be very difficult for staff person to “maintain that professional demeanor and approach.” The VA would engage in behaviors such as spitting on staff persons, using racial slurs, and smearing bodily fluid on staff persons in December 2023, which resulted in additional staffing concerns.
- P3 said the facility did not review the camera recordings 24/7, but would review the recordings on an as needed basis related to incident reports that staff persons documented. However, there were some inconsistencies from staff persons documenting the concerns. P3 reviewed all of the videos with this investigator and was not aware of all of the incidents prior to January 2024.
- P3 said some of the restraints within the recording were completed without imminent risk to the VA or other persons. P3 added that there were times staff persons followed the trainings, however, there were staff persons that should have responded differently toward the VA, and did not follow their training. P3 said staff persons engaged in power struggles, continued engaging with the VA while s/he had behavior which escalated situations. P3 said staff persons were not trained to engage in antagonistic behavior, posture, or make threatening statements toward the VA.
- P3 said during the situations when there was imminent harm, “it is not always easy” to complete a EUMR.

P3 said during the incident on November 17, 2023, SP1 attempted to complete the one-person restraint to the best of his/her ability, and during the supine restraint completed by SP1 and SP2, it appeared to be done safely and there was imminent harm.

- P3 said staff persons did not need to close the VA's bedroom door, or block the VA's access to his/her bedroom. P3 said if the VA attempted to leave without supervision out his/her bedroom window there was an alarm that would sound.
- P3 said the use of the previous staff person's name was not "appropriate," and went against the training the facility provided staff persons. P3 said the use of the previous staff's name was "threatening."
- P3 said there were instances that staff persons would threaten taking away community activities from VA, and the facility completed a re-training to ensure that did not occur in the future.

SP1-SP9, P1-P3 were each trained on the Reporting of Maltreatment of Vulnerable Adults Act, the facility's policies and procedures, the VA's client specific programming, professional documentation, an intro to mental health, and functional assessment. The functional assessment training included a review of the role of a direct support professional, and understanding behavior and behavior supports plans. SP1-SP9, and P1-P3 were also trained on "In-Person Positive Support Rule" which included de-escalation techniques, EMUR, service recipient rights, self-care, and positive support role training.

Conclusion:

The VA's client specific documentation showed the VA's history and behaviors as well as strategies for staff persons to use to support the VA. The VA had a history of attempting to find the "weakest link," which was observed within the recordings. The VA's documentation also stated EUMR's should be used if the VA posed imminent threat to him/herself or others. Staff persons' training included an understanding of the VA's behaviors, the VA's *Crisis Protocol*, and EUMR. The VA's behavior was outlined in his/her client specific documentation, and during interviews staff persons described the VA as difficult to provide care and services to, which was also stated by the VA's team members.

There were multiple reports involving the VA and staff persons (SP1-SP9) from November 2023, through late January 2024, that were captured on video recordings. The recordings likely did not show the entirety of the interactions, as there was more likely than not interactions between staff persons and the VA prior to the recordings. The recordings showed there were times staff persons attempted to utilize the strategies and supports, however often staff persons did not follow the strategies and supports that were stated in the VA's client specific documentation. The recordings also showed there were times staff persons utilized an EUMR as a potentially preventative action or blocked the VA from a portion of the facility, however in all of the incidents the VA demonstrated escalated behavior and engaged in behaviors that were described in the VA's client specific documentation.

Regarding two incidents of the VA being denied access to a phone:

Video recordings from December 26, 2023, and January 4, 2024, showed that the VA asked to use the phone. On December 26, 2023, the VA used racial slurs and was escalated so SP6 did not allow the VA to use the phone. On

January 4, 2024, the VA was yelling and pounding on the wall "demanding" to use the phone. SP2 told the VA that s/he was agitated but the VA disagreed.

The VA had a rights restriction regarding the use of the phone including that staff persons needed to dial the number and use speakerphone and if the VA was being unsafe the call would be ended. The rights restriction also outlined who and when the VA could call.

Although it was not specified in the VA's plans that s/he could not use the phone when agitated, given that it was reasonable for the VA to be calm prior to staff persons assisting the VA with making a call and that there was no information that the VA was not assisted with a phone call at a later time, there was not a preponderance of the evidence whether there was a failure to provide 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).

Regarding SP1 and SP2:

The recording from November 17, 2023, showed SP1 completed a one person standing one arm restraint, and moved the VA from the hallway to the living room. Thereafter, SP1 and SP2 completed a two person EUMR. Prior to the EUMRs the VA had engaged in verbal and physical aggression toward SP1 and SP2, and attempted to enter the staff office. During the incident SP1 and SP2 attempted to follow the VA's client specific programming, however, the VA's behaviors continued to escalate, and the VA attempted to engage staff persons in a power struggle over the telephone. The VA's escalation continued toward SP1 and SP2 and included hitting SP1's leg and foot multiple times, slapping SP1, and spitting at SP2. During the physical aggression SP1 and SP2 appeared to maintain a calm demeanor, and SP2 moved the VA's glasses and said s/he did not want the VA to break his/her glasses.

There was no information obtained that supported SP1 broke VA's wrist brace, pinched the VA's arm, threw VA's head against the wall, pulled VA's hair, and punched VA in the head. The video did not show the VA and SP1 go into the VA's bedroom.

In addition, on January 27, 2024, SP2 was involved in a EUMR of the VA. However, there were no concerns with the EUMR or SP2's actions.

Although the VA had bruising at, or near, the location (VA's left arm) that SP1 had a hold of during the EUMR, given that the recording supported the use of an EUMR, that it was not able to be determined how the bruises were caused, and that SP1 and SP2 attempted to disengage with the VA, there was not a preponderance of the evidence whether SP1's or SP2's engaged in conduct that would be reasonable expected to produce pain or injury or whether there was a failure to provide the VA with reasonable and necessary care and services.

It was not determined whether physical abuse or neglect 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; 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).

Regarding SP3 and SP4:

It was reported that SP3 and SP4 were working with the VA, and taunted, criticized, laughed at the VA, called the VA names, "got in VA's face," and put VA in unnecessary restraints.

The 47-minute recording from November 30, 2023, showed the VA was escalated throughout the incident, and engaging in verbal and physical aggression toward SP3-SP4, however within the recording SP3 and SP4 criticized the VA, called the VA a liar, and laughed at the VA. Additionally, SP3 and SP4 had physical contact with the VA, and SP3 stated, "Stop hitting us," and "We only do a hold if you hit." SP3 and SP4 had physical contact with the VA after the VA attempted to enter the staff office and resulted in a brief EUMR where SP3 and SP4 held the VA's wrists. SP3 and SP4 engaged in a EUMR by holding the VA's wrist after it appeared the VA was preparing to use his/her bodily fluids to touch SP4. During the interaction SP3 stated, "You are gross and that is nasty."

The VA, SP3, and SP4, had on-going verbal and physical interactions during the recording. The VA used racial slurs, derogatory statements, and engaged in physical aggression towards SP3 and SP4, however, during the interactions SP3's and SP4's verbal interactions with the VA did not de-escalate the VA's behavior, nor were those strategies the facility trained staff persons to use. There was no information the VA was harmed during the incident; however, SP3's and SP4's behavior was inconsistent with the standards of professional caregivers in a facility licensed by the Department of Human Services. Given that there was no other information which showed SP3 or SP4 had engaged in similar conduct, there was not a preponderance of the evidence whether SP3 and or SP4 engaged in repeated or malicious conduct that could be reasonably 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).

In addition, although it was reported that SP3 and SP4 used unnecessary restraints, given that restraints were used when the VA was hitting, pushing, and attempting to bite SP3 and SP4 and that the VA was not injured, there was not a preponderance of the evidence whether SP3 or SP4 engaged in conduct reasonable expected to produce physical pain or injury.

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 SP6:

Information including a video recording from December 26, 2024, showed that during an interaction between SP6 and the VA, SP6 told the VA, "You are the only one that is stupid," and SP6 and the VA each called each other a "cunt."

A video recording from December 30, 2023, showed that SP6 made a comment to the VA about rape, said the VA was sexually assaulting someone, told the VA to "keep your fucking mouth away from me," and called the VA a rapist.

Given that SP6 called the VA stupid and a "cunt" during one incident and then called the VA a rapist and told the VA s/he was sexually assaulting, there was a preponderance of the evidence that SP6 engaged in repeated oral language that would be considered derogatory and harassing and would be reasonable expected to produce emotional distress.

It was determined 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).

In addition, a five-minute video recording from December 26, 2023, at 4:10 p.m. showed that the VA initiated physical contact with SP6, and additional verbal and physical interactions occurred thereafter. SP6 made physical contact with the VA, with most of the contact not being trained EUMRs, and included pushing the VA to a seated position on a couch four times. Initially SP6 used his/her shoulder to push the VA onto the couch in a seated position, then when the VA attempted to stand, SP6 pushed the VA's chest to make the VA sit back down. Again, the VA attempted to stand and grabbed SP6 who fell onto the VA pushing his/her arm against the VA's neck. The fourth time the VA attempted to stand SP6 put his/her body weight on the VA and the VA sat back on the couch and SP6 sat next to him/her. SP6 then put his/her arm with pressure across the VA's throat.

Given SP6 pushed the VA onto the couch preventing the VA from standing and continued to engage with the VA not according to training instead of moving away, there was a preponderance of the evidence that SP6's conduct was not accidental and could be reasonably be expected to produce pain and that there was a failure to provide the VA with reasonable and necessary care and services.

It was determined that physical abuse and neglect 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; 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).

Regarding SP7:

Regarding an incident on December 26, 2023, at 3:30 p.m.:

A video recording from December 26, 2023, at 3:30 p.m., which was approximately two minutes long showed an incident of the VA being verbally and physical aggressive. SP7 made comments to the VA about the VA being "dizzy." Then, the VA walked directly into SP7, and SP7 responded by using his/her chest/shoulder to keep the VA in front of him/her. SP7 continued to provide the VA with directives to sit down and said, "You are dizzy," before the VA walked toward the hallway and out of the camera view.

Given the information from the video did not show SP7 engage in conduct that rose to the level of maltreatment, there was a preponderance of the evidence that SP7 did not fail to provide the VA with reasonable and necessary care and services.

It was determined that neglect did not occur (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).

Regarding SP8:

A video recording from December 26, 2023, at 4:10 p.m., showed that the VA attempted to bite SP6 while seated on a couch so SP8 while standing put his/her hand on the VA's forehead applying some pressure for approximately twenty seconds. The VA did not appear to be injured.

In addition, on January 27, 2024, SP8 was involved in a EUMR of the VA. However, there were no concerns with the EUMR or SP8's actions during this incident.

Although SP8 was not trained to put his/her hand on the VA's head, given it did not appear to harm the VA and SP8 used some pressure but not excessive pressure, and that the VA was attempting to bite SP6, there was not a preponderance of the evidence whether SP8's actions would be reasonable expected to produce pain or injury.

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).

A video recording from December 30, 2023, starting at 6:47 p.m., showed a verbal and physical interaction involving the VA, SP6, and SP8. SP8 blocked the VA's bedroom door more than once and screamed into the VA's face three or more times, one time so loud the words were not audible. SP8 also laughed at the VA, postured, and continued to engage the VA in a way that was not according to the VA's plans to deescalate the VA, so the VA continued to be agitated.

Given that SP8 screamed in the VA's face three or more times and continued to engage with the VA by blocking the VA's room, posturing, laughing, and not walking away, there was a preponderance of the evidence that there was a failure to provide the VA with reasonable and necessary care and 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).

Regarding SP9:

A video recording from December 26, 2023, showed an incident of the VA being physical and verbally aggressive toward SP6, SP8, and SP9. SP9 pointed his/her finger in the VA's face multiple times while talking to the VA and used a previous staff as a threat toward the VA. However, SP9 also attempted to disengage from the VA's interactions multiple times.

Although SP9's behavior was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services, given this was a single incident there was not a preponderance of the evidence whether SP9's conduct was repeated and rose to the level of emotional abuse.

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).

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.

SP6 and SP8 were trained on the Reporting of Maltreatment of Vulnerable Adults Act, the VA's client specific programming, the facility's policy and procedures, and EUMR. SP6 and SP8 were responsible for maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

"Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

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 emotional abuse, physical abuse, and neglect that SP6 was responsible for were each not "serious" maltreatment because the VA was not injured. However, because there were two separate incidents of substantiated maltreatment SP6 was responsible for, it was determined to be "recurring" maltreatment.

SP6 was disqualified from providing direct contact services.

It was determined that the substantiated neglect for which SP8 were responsible was not "recurring" maltreatment because it was considered one incident and not "serious" maltreatment because the VA was not injured.

Action Taken by Facility:

The facility completed internal reviews for the allegations and determined that the policies and procedures were adequate, but not followed. The facility completed additional staff training, and took corrective action to protect the persons that received services. The report was similar to past events as the VA had a history of behavioral interventions which included the use of EUMR.

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

SP6 was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that SP6 was responsible for maltreatment and the disqualification of SP6 are each subject to appeal.

SP8 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP8 was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of SP8. The determination that SP8 was responsible for maltreatment is subject to appeal.