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: 202410631

Date Issued: November 12, 2025

Name and Address of Facility Investigated:

REM Ramsey, Inc. - McKnight
932 McKnight Road South
Maplewood, MN 55119

REM Ramsey, Inc.
6600 France Ave S #500
Edina, MN 55435

Disposition: Substantiated as to physical abuse of a vulnerable adult by a staff person.

License Number and Program Type:

1071834-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071829-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) hit a vulnerable adult (VA) on the head and squeezed the VA's hand with enough force to cause a bruise.

Date of Incident(s): December 4, 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 subdivision2, paragraph (b), clause (1):

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

Summary of Findings:

Pertinent information was obtained during a site visit conducted on January 2, 2025; from documentation at the facility; and through seven interviews conducted with the VA, the VA's two case managers (CM1 and CM2), the VA's family member (FM), two staff persons (the SP and P1), and two supervisory staff persons (P2 and P3).

The VA's diagnoses included a history of a stroke, dementia, generalized anxiety disorder, major depressive disorder, major neurocognitive disorder, secondary parkinsonism, adjustment disorder, and cluster B personality disorder. The VA liked to fish, watch television, and spending time with his/her family. The VA also liked motorcycles and woodworking. The VA used a wheelchair that did not have a lapbelt and needed assistance with transferring, positioning, bathing, and dressing. The VA was on coumadin and warfarin medications that made him/her more suspectable to bruising. The VA not subject to guardianship.

The VA's *Coordinated Services and Supports Plan* stated the VA had a history of verbal aggression and "minor physical aggression." The VA can be "easily frustrated" and "easily agitated" to the point where s/he might "yell/scream" at others and be "violent." The VA's *Action Plan* stated when the VA showed s/he was "frustrated," staff persons were to "stop talking" and give verbal prompts in a "simple and in a calm manner." Staff persons were to "never threaten" the VA.

The VA's *Individual Abuse Prevention Plan* provided the following information:

- If the VA was physically aggressive, staff persons were to "maintain distance and attempt redirection using des-escalation skills."

- If the VA was verbally aggressive, staff persons were to "take a calm understanding approach" and "reinforce positive communication and behavior." Staff persons were to "refocus the conversation without directly calling out the abusive behavior."

- The VA's "has a history of making unfounded accusations due to [his/her] cognitive impairment."

The VA provided the following information:

- The VA had lived at the facility for four to five months and s/he thought it was "so far so good." The VA did not get along with staff persons because they were "belligerent," but they were "pretty forgiving" of the VA.

- The VA did not get along with the SP. The SP acted like the VA "[did] not have a reason to be here" and did not want the VA to live there. The VA gave inconsistent information about the SP. The VA denied the SP was ever loud with him/her, but also said the SP "yell[ed]" at the VA to "behave yourself."

- "A couple [of] months ago," the SP worked with P3 and P1, and the VA was on the floor. (Note: Information obtained showed that P3 was not working at the time of the incident. P1 – P3 and the SP each shared that it was not unusual for the VA to slouch and slide out of his/her wheelchair onto the floor.) The SP "forced" the VA do "do something," but s/he was not able to recall what that was. The SP tried to help the VA up and "decided" to "intentionally stomped on [the VA's] hand" and "crushed" it. The VA did not recall the SP hitting him/her or what was said during the incident. The VA was not able to remember any other details of the incident.

- The VA's hand hurt, and s/he had a "purple" bruise on his/her hand and finger that lasted "three weeks." The VA's hand was "fine" by the time of his/her interview.

P1 provided the following information:

- The SP's and the VA's interactions had "not been good." The SP "looked stern" when working with the VA. When the VA was upset, staff persons talked through things with him/her and the VA "adjusted" and calmed. When the VA called out to staff persons for help, the VA did not always appear to need something, but wanted attention with some small tasks. It was "rare" for the SP to "[rush]" to the VA's calls for help.

- On an unknown date in early December 2024, P1 worked in the evening with the SP. P1 usually worked overnight shifts but picked up shifts in the evening with the SP a "few" times prior. There was "nothing strange" that happened earlier in the shift. After dinner around 6:30 p.m., P1 cleaned and washed dishes while the SP prepared the medications. Medications were passed between 7 to 8 p.m., so the SP was doing them "early."

- During this time, the VA yelled asking to be put into bed. P1 then asked the SP for help to move he VA, but the SP said, "No, let [him/her] yell." P1 went into the VA's room and the VA was "almost out of [his/her] chair" and his/her "butt was more than halfway off" the seat. P1 thought the VA "might slip at any time." P1 said, "Hold on" and that she needed to "get someone to help." P1 was not able to transfer the VA on his/her own so s/he went to get the SP.

- When P1 told the SP, "Let's go pick [the VA] up" to move the VA to the bed, the SP said, "No, if [the VA] wants to fall, let [him/her] fall." P1 told the SP that if the VA fell, it made "double work for us" and that it was "better" to get the VA into bed, so s/he was "safe." The SP said, "You can see that I am busy." P1 reminded the SP about practicing "safety first" and "insisted three to four times" for the SP to help with the VA. The SP appeared "mad" at P1's repeated attempts before the SP agreed to help, but the SP was "not happy about it."

- P1 and the SP went into the VA's bedroom and saw the VA "at the edge" of his/her wheelchair. The VA was "upset" with having to wait for help. The VA "curs[ed]" and "yell[ed]" at the SP, "I will hit you." The VA moved his/her arm appearing to be "attempt[ing]" to hit the SP. While the SP and P1 "ignore[ed]" the VA's aggressions, the SP appeared "not happy" and was "quiet" and "just moody."

- The SP put the EZ Stand sling behind the VA and planned to lift the VA with the EZ Stand. P1 said they needed to "scoot" the VA back before they attempted to move him/her. The SP did not listen to P1 and began to use the EZ stand to lift the VA. P1 told the SP that the VA was "going to fall," but the SP continued.

- The VA "slipped and fell off the chair" so s/he was seated on the floor with his/her head "supported" by the wheelchair. The fall was "not hard" because the VA's chair was "not that high." As the SP tried to position the Hoyer in front of the VA, the VA called the SP a "motherfucker" and "asshole" and s/he was going to "hit" and "kill" the SP. The SP stood over the VA and said, "If you want to hit me, hit me," and then the SP "swift[ly] hit" the VA on the "center" of the VA's face with the "back of [the SP's] hand." The hit was "slight" and "not heavy." P1 said it was a "five" on a scale of one to ten. The VA became "agitated" and "mad," and then said to the SP, "Fuck you, I'll kill you."

- P1 asked the VA if s/he okay and the VA said s/he was "fine," but it appeared "was not comfortable" because his/her "foot was not straight." P1 and the SP repositioned the VA and moved the wheelchair, so the VA lay on the floor while they tried to figure out what to do next. The SP attached the EZ Stand sling into the Hoyer Lift mechanism. Though P1 said that it was "not a sling for the Hoyer," the SP continued to place it on the VA. P1 positioned him/herself near the VA's head due to concerns the VA might swing around while s/he was lifted and hit his/her head on furniture. When the SP used the Hoyer to try to lift the VA, only the VA's arms began to lift up, and the VA was returned the floor. The VA became upset told the SP, "I will kill you, you asshole motherfucker." The VA then moved his/her arms as if s/he "want[ed] [the SP] to come close" and said, "I will hit you," and "I am going to kill you."

- The SP "stood over" the VA. The SP asked the VA, "You want to hit me? You want to kill me?" The SP then bent over and with his/her right hand, "grabbed" the VA's right hand which the VA was swinging at the SP. The SP "squeezed it," and then "twisted" and "pressed" it to the VA's chest. The SP said, "You want to hit me, go ahead and hit me... let me see you do it." P1 said that at that time, both the SP and the VA were "mad."

- P1 told the SP, "Please stop," but the SP did not listen or say anything to P1. The SP was "really angry" and squeezed the VA's hand. P1 "begged" the VA, "Please be calm," and told the VA that s/he was not able to lift the VA by him/herself. P1 also told the VA, "Please stop cursing and just be calm so we can get you into your bed." The VA said, "Okay" and calmed and then the SP released the VA's hand. The SP in total squeezed the VA's hand for "about a minute" before releasing it. During this time, the VA was "quiet" and "calm." P1 thought due to his/her and SP1's culture there was a "limit" to what s/he was able to do in that situation. P1 and the SP started to work out how to get the VA off the floor.

- The SP left the bedroom and then came back with the Hoyer sling which the SP and P1 used to get the VA into bed, where they cleaned and changed the VA, after which the SP left the room. P1 stayed and finished helping the VA get ready for bed before s/he left the room. When P1 went into the common or office area, s/he saw P2 talking with the SP. P1 did not know how long P2 had been at the facility, but thought it might have been "a while" given the amount of groceries that appeared to be put away. P2 and the SP were talking in a language P1 did not understand, but P1 "deduced" they were talking about what happened with the VA. P2 told P1, "You know, that is how [the VA] behaves." P1 did not talk to the SP about it either.

- P2 did not ask P1 about the incident and P1 did not tell P2 about the incident because they did not have a "quality relationship" and P1 did not think P2 would do anything about the situation. If the situation did not involve P2, P2 did "not care" about it. P1 thought if P2 was at the facility, s/he must have heard the noise coming from the VA's bedroom, but decided to stay where s/he was and not look into it.

- On December 5, 2024, at an unknown time, P1 worked with the VA and saw a bruise on the back of the VA's right hand, in the location the SP squeezed it, that looked "greenish" and covered "half" of the VA's hand. P1 did not think the VA had other similar bruises in the past in the same area that the SP squeezed the VA. There was no bruise on the VA from where s/he fell to the floor or where the SP hit the VA in the face. P1 did not see any bruises or marks on the VA's face.

- There were interpersonal conflicts between P2 and P1 and historically P2 did not followed up on other marks on the VA. When P1 talked to P3 about the situation, P3 was not aware of the incident.

- Prior to the incident, there were previous occasions when the SP made comments when the VA yelled out for things to "let [him/her] yell." P1 said it was only "rare cases" where when the VA "shout[ed]" for assistance and the SP "rush[ed]" to help. This was the first time the SP said anything about letting the VA fall. This was also the first time the VA ended up on the floor when the SP decided not to immediately respond to and the VA.

- On December 10, 2024, P1 stopped by the facility for something and saw P3 pull up. P1 told P3 what happened between the SP and the VA and P3 went inside to talk with the VA. P1 "forgot" to do a shift note from the situation and was told by P3 to do a "late entry."

P1's *Note Summary Report* dated, December 10, 2024, stated:

- After dinner, the VA "yelled begging for help" getting into bed. P1 asked the VA to have "a little patience" while P1 finished up with dinner and the dishes. About "30 minutes later," the VA again yelled about wanting to get into bed and that s/he was "falling from [his/her] wheelchair." P1 "quickly" went into the VA's bedroom and saw the VA "sliding off the chair."

- P1 "quickly" left and went to the SP for help to get the VA back in his/her chair. The SP "declined" to help because s/he was "busy prepping medications." P1 "insisted" the medications could wait because this was a "safety... priority." The SP and P1 then went into the VA's bedroom where the VA was "almost off the chair." The SP and P1 were unable to lift the VA back into his/her chair and the VA "slid to the floor." The SP left the bedroom and came back with the Hoyer lift and tried unsuccessfully to use the EZ Stand sling to get the VA up.

- The VA and the SP yelled "back and forth" at each other and the VA "curs[ed]" at the SP. The SP "hit [the VA] on the face." The VA "got more pissed" and tried to "hit [the SP] back." The SP "held [the VA's] hand while squeezing on [his/her] chest as [the VA] layed [sic] on the floor."

The SP provided the following information:

- The VA was "not friendly," and VA often yelled and shouted racial slurs towards others including the SP. When staff persons assisted the VA with tasks, if the VA did not like the staff, s/he said they were trying to kill or rape him/her. If the SP were to just touch the VA's head, the VA might say the SP was "hurting me." The VA kicked, kneed, and hit staff persons, including the SP, to the point of pain and injury. The VA injured the SP's genitals and hit him/her in the face breaking the SP's eyeglasses. Staff persons often chose not to work with the VA or at the facility due to the VA's behaviors. When the VA was aggressive the SP was trained to not talk back and to give the VA space to calm.

- The SP said the VA might take off the lapbelt while in his/her wheelchair and lean back in a manner causing him/her to slide out of his/her seat. When the VA was on the floor, staff persons were to use the Hoyer Lift to lift the VA from the floor VA into his/her wheelchair, and then the EZ Stand from the wheelchair to the bed.

- The SP denied the incident between him/her and the VA occurred. The SP denied s/he ever said that if the VA was slipping out of his/her chair to let him/her fall. When the VA was on the floor, the SP only ever did what s/he was trained and told to do when trying to get the VA up from the floor. The SP denied s/he ever tried to use the EZ Stand sling on the Hoyer Lift.

- The SP denied s/he ever squeezed the VA's right hand in a manner to leave a bruise. The SP said that the only time s/he ever grabbed the VA's hands was when the VA was lying on the floor and the SP did so to help the VA sit up to put the Hoyer Lift sling around him/her. The SP grasped the VA's hands in a manner as if shaking hands to help the VA into a sitting position. Only one time went this happened did the VA say the SP "squeez[ed] [his/her] finger." The SP did not think it was enough of a grasp to cause a bruise. The SP never saw any bruises on the VA's hand nor talked with P2 after an incident after the VA was on the floor.

- While the SP did not remember when, around the SP's last shift before s/he took time off from the facility and the alleged incident occurred, there was a situation that the SP thought might be why the VA's bruised hand. The VA was in the EZ Stand and the SP was behind him/her cleaning up after a bowel movement. The VA swung his/her arm and tried to hit the SP, when the EZ Stand and VA fell over. The SP thought it was possible the VA got the bruise on his/her from that. The SP did not document when this happened but told the other staff person to.

- The SP denied s/he ever hit the VA on the forehead nor told the VA to him/her and if others said they saw it happen that was "a lie."

P2 provided the following information:

- The VA required assistance with transferring, positioning, dressing, bathing, and toileting. The VA struggled to recall events such as whether s/he already ate breakfast that day, telling staff persons s/he had a visitor earlier when s/he did not, and struggling to understand timeframes.

- At time when the VA was in his/her room in his/her wheelchair s/he might attempt to reposition him/herself. The wheelchair did not have a lapbelt or anything to hold the VA in position. The VA also "slouched" in his/her wheelchair, slipping out of the chair to sitting on the floor with his/her back to the wheelchair. When the VA was found sitting on the floor, staff persons were to make sure the wheelchair was locked, and two staff persons were to get on either side and "pull" the VA back up into the chair. Staff persons might also use the EZ Stand or Hoyer Lift to get the VA off the floor.

- The VA "always" screamed and yelled at staff persons even when they were helping him/her, threatened to kill them, and tried to hit them. The VA often targeted the SP, used racial slurs, and tried to hit the SP in his/her face, eye, and genitals "almost every time" the SP worked. The SP was the "most constant" staff person with the VA and "always complained" about the way the VA talked to him/her.

- Staff persons were to redirect the VA, try to distract him/her to something else of interest, or offer something the VA might want instead. Staff persons could also tell the VA they were not going to participate, walk out of the room, and try again later when the VA "calm." When the VA attempted to grab at staff persons, they were to verbally redirect the VA and walk out of the room.

- On December 10, 2024, P2 was at the facility and then went grocery shopping. Between 6:30 and 7 p.m., returned and heard the SP and P1 in the VA's bedroom attending to the VA who was complaining about how the SP cleaned him/her after a bowel movement. When the SP came out, P2 could see "something was off" with the SP because s/he appeared "bottled up" and "not excited." P2 asked what happened and the SP said it was the same thing that the VA had been doing and "nothing new." They discussed the difficulty with helping the VA to clean after a bowel movement, the VA's reactions, and how to handle it in the future.

- P2 was not at the facility very long finishing his/her work and clocking out. P1 did not say anything to P2 about what happened in the VA's room. P2 did not see the VA before s/he left but did so the next day and the VA seemed his/her "normal self." P2 denied having a discussion about a physical interaction between the SP and the VA. On December 10, 2024, P2 learned about the allegation from P3.

- On December 10, 2024, P3 told P2 that the VA had a bruise. P2 then asked the VA how s/he was, the VA said, "[The SP] hit me." P2 did not ask more questions. The VA told P2 inconsistent information regarding how s/he sustained the bruise on his/her hand, the VA said s/he was not sure where it came from, but also said, "[The SP] squeezed my hand."

P3 and a photo taken by P3 provided the following information:

- The VA provided accurate information about incidents and repeated statements several times when s/he was "serious" about something. With the VA's "early stage" dementia, if s/he did not recall something s/he told staff persons that s/he did not remember. When the VA "made things up," it was usually his/her "sense of humor" and there was a "smile at the corner or [his/her] lips." The VA might say untrue things to the FM about when the VA "yells" at the facility because s/he "does not want to get in trouble." The VA was "pretty aware" and "under[stood] everything" that happened around him/her but "struggle[d]" with how long time passed. When the VA was upset, s/he called staff persons names and hit them. The VA became upset when s/he felt that tasks were delayed or not done in the was s/he wanted. Staff persons were trained "not to take everything personal" that the VA did or said.

- The VA's wheelchair did not have a lapbelt. When the VA "need[ed] attention" for something, s/he would "slide down" in his/her wheelchair and then call out for staff persons assistance. The SP got "upset" when the VA did this to get attention. The VA required two staff persons assistance to transfer.

- The SP "complain[ed]" about the VA's behaviors and denied s/he did not do what the VA asked of him/her. The SP took the VA's verbal aggression "very personal" and said in staff meetings that the VA "just doesn't like me." When the SP talked about when the VA "lash[ed] out," the SP did not acknowledge what s/he might have done that led to the VA being upset.

- On December 10, 2024, P3 went to the facility after being gone for several days. P1 asked P3 to look at the "back of [the VA's] right hand" for "a bruise." P3 went to check on the VA and asked how s/he was doing and how s/he got along with staff persons while P3 was away. The VA said, "[The SP] squeezed my

hand so hard it turned blue black" and then showed P3 his/her hand. P3 saw a bruise on the VA's hand. The VA could not remember details of what happened, but recalled that another staff person was present at the time. P3 took a photo of the bruise and then went to talk to P2. P3 asked P2 about the situation, s/he said s/he was not aware of it nor were there reports from staff persons about any bruises on the VA.

- P3's photo taken on December 10, 2024, showed two distinct irregular margined purple and black bruises on the back of the VA's right hand in between the first and middle knuckle on the half closer to the fingers with yellowing in between the bruises, surrounded by age spots. A photo taken on January 2, 2025, showed slight discoloration and age spots, but no bruises.

- At that time, P1 provided information to P3 that was consistent with the information P1 provided during his/her interview. P1 also told P3 that when s/he saw how "upset and angry" the SP was at the time s/he did not want to "make it worse" by "standing up" to the SP. P1 instead focused on getting the VA up from the floor safely. P3 asked P1 why s/he did not notify P2 about the incident, P1 said that after the incident when P2 and the SP were talking, s/he thought they were discussing it and P2 did not ask P1 about the incident.

- Later that day, P3 called the SP who said the bruise was from the VA's fall, which the SP did not document.

- P3 was not aware of any previous similar bruises from the VA's previous falls. The SP was trained to use his/her forearm to block possible hits using the area between the elbow and the hand to block any attempts at being struct. Training did not instruct the SP to grab or hit in any situation.

The FM provided the following information:

- The FM called the VA every other day. The VA's short-term memory was "not great" and s/he had "trouble explaining [him/herself." The VA might not always give the same information twice, might not remember details, and struggled to understand timeframes and how much time had passed. The VA "struggle[d]" to understand what staff persons said to him/her and did not feel heard or understood by them, which created "tension."

- The VA and the SP had difficulty communicating and the SP struggled to understand what the VA said. The SP tried to "defuse" situations with laughter or thought the VA was laughing, which upset the VA. On occasion, when the FM was on the phone with the VA, the FM heard the VA and the SP yelling at each other. The SP told the VA s/he "need[ed] to calm down" and that the VA was "lying" when s/he said things. The FM never heard the SP say anything insulting, humiliating, or swear at the VA.

- On December 11, 2024, P3 emailed the FM about a "complaint" that a staff person "squeezed [the VA's] hand until it bruised." That day, the FM called the VA who said a staff person squeezed his/her hand, but the hand was "feeling better" now.

- On December 15, 2023, the FM went to the facility and met with the VA and saw the bruise. The VA said the SP squeezed his/her right hand, while P3's emails said it was the left. [Note: All other information provided showed that it was the VA's right hand.] The FM was not aware of the SP hitting the VA.

CM1 did not have any relevant information to provide.

CM2 said that due to the VA's "memory decline" s/he might be "very forgetful" and be "foggy." The VA "curse[d] out" staff persons and made "racial comments" towards them. The facility reported that the VA was "quick to anger" and "physically assault[ed]" staff persons so they wanted to get additional supports in place. At times the VA's behaviors made staff persons "uncomfortable." CM2 did not have any information to provide regarding the incident.

Facility documentation showed that P1–P3 and the SP each received training on the Reporting of Maltreatment of Vulnerable Adults Act, facility's policies, and on the VA's plans prior to the incident. The SP was also trained on Positive Behavior Supports, Mental Illness: Crisis Response, and De-Escalation.

Conclusion:

A. Maltreatment:

P1 and the VA provided consistent information to P3, the FM, and/or during their interviews that the SP squeezed the VA's hand and soon after bruises were seen. Although the VA's said during his/her interview that the SP "stomped" on his/her hand, s/he was consistent that the SP injured his/her hand and was consistent to P3 more than one time and to the FM that the SP squeezed the VA's hand. P1 also stated that at one point the SP stood over the VA and "swift[ly] hit" the VA on the "center" of the VA's face with the "back of [the SP's] hand." Although the VA did not provide this information to P3, the FM, or during his/her interview, the VA was diagnosed with dementia and the VA did not sustain any injury on his/her face.

The SP denied hitting the VA and/or squeezing the VA's hand and stated the bruise may have been from the VA previously falling out of the EZ Stand. But there was no documentation to support this and no one interviewed saw similar bruises on the VA from past falls. Given that P1 and the VA provided the same and/or similar information that the SP grabbed and squeezed the VA's hand, that the VA then had a bruise on his/her hand, that there was no information to discredit P1's account that the SP slapped the VA on the face, and that the SP had reason to minimize his/her interactions for fear of repercussions, there was a preponderance of evidence that slapping a face and squeezing a hand was not accidental or therapeutic conduct and could reasonably be expected to produce physical pain or injury.

It was determined that 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).

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.

The SP was trained on the VA's plan; Positive Behavior Supports, Mental Illness: Crisis Response, and De-Escalation; and on the Reporting of Maltreatment of Vulnerable Adults Act. The SP was 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 physical abuse for which the SP was responsible did not meet statutory criteria to be determined as recurring because it was a single incident. However, it was serious maltreatment because the VA sustained a bruise on his/her hand.

The SP was disqualified from providing direct contact services.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed.

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

The SP 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 the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.