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: 202502085

Date Issued: November 5, 2025

Name and Address of Facility Investigated:

REM Woodvale, Inc.-Shirewood
1400 4th Avenue Southeast
Austin, MN 55912

REM Woodvale, Inc.
6600 France Avenue South, Suite 350
Edina, MN 55435

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

License Number and Program Type:

1071971-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071970-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that staff did not intervene when a vulnerable adult (VA) built a homemade "pipe bomb" or "firework" and instead, allowed the VA to "detonate" it causing "a loud explosion."

Date of Incident(s): March 10, 2025

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (a):

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information for this investigation was obtained during a site visit on March 20, 2025; documentation from the facility and law enforcement records; and through six interviews conducted with the VA, the VA's guardian (G), the VA's case manager (CM), a facility staff person (P1), and supervisory staff persons (P2 and P3). Additional staff persons (P4, P5, P6, and P7) were interviewed for the facility's *Internal Review* and their information was included in this report.

The VA's support plans, including October 2024 *Team Meeting Minutes*, stated the following:

- In October 2024, the VA moved into the facility seeking support and services relating to his/her diagnoses, which included autism spectrum disorder and selective mutism (anxiety disorder characterized by an inability to speak in specific social situations).

- The VA had "unlimited" unsupervised time in the community and up to six hours unsupervised time at the facility. The VA wanted to be as independent as possible and "left alone at all times." The VA did not verbally communicate with many or any staff and instead conversed by typing messages on his/her cellphone and then showing his/her cellphone to the staff.

- The VA was independent with all cares and had no prescribed medications. However, the VA might "freeze" in potentially abusive situations and might refuse routine- and emergency-medical attention. Staff provided education and support and reminders to the VA as needed, and helped with meal preparation, household management, and meaningful engagement and activities.

- The VA liked taking things apart, understanding how things work, and repurposing things. "[The VA] loves science and experimenting with chemicals (making/building fireworks), and lasers … [The VA] is very careful with all of [his/her] chemicals and knows which ones [s/he] can mix together." The chemicals were labeled and locked in a utility cabinet in the VA's bedroom. The VA had a fire extinguisher and baking soda in his/her bedroom for fire prevention. [Note: The plans reviewed for this investigation did not state if the VA was allowed to build fireworks or what staff were supposed to do regarding the VA's experiments.]

- The VA might need help avoiding "risky or ambiguous situations." The VA always kept his/her cellphone with him/her and contacted staff if s/he needed assistance. If the VA was displaying behaviors such as mixing chemicals, property destruction without injury, or refusing to maintain cleanliness of his/her personal space and there was not a need for an immediate response, staff contacted the G, the CM, and the VA's family member to discuss the risk and "[*illegible*] to mitigate that risk in the future."

- Note: The facility's *Internal Review* included information from the VA's *MNCHOICES Assessment*, which stated that between February and April 2023, the VA lived with his/her family member and during that time, the VA engaged in "unsafe and harmful behaviors" resulting in the family member calling the police with safety concerns. "[The VA] was arrested and spent some time in jail in April 2023." The VA then moved into a hotel and other "short-term" housing. In August 2023, the VA moved into a home with staffing support, and then in October 2024, the VA moved into the facility. The CM said that the VA's arrest in 2023 was related to "shooting something off" and the police finding "explosive materials" in the VA's possessions. P2 and P3 told the DHS investigator that they heard during the VA's team meeting or from the VA directly that his/her belongings at his/her old house were "raided" by the police. When the VA moved into the facility, s/he had an upcoming court date; however, P2 and P3 did not have information about what this entailed. Criminal charges relating to this court date were dropped.

The facility was a single-family home where the VA lived with housemates. The facility was within the city-limits and backed up against a field with neighboring housing nearby. The facility provided at least one staff person 24-hours a day for the VA's and his/her housemates' care and supervision.

There was a park about 0.1 miles outside of the city limits. The park contained multiple pavilions, picnic shelters and tables, playgrounds, walking and biking trails, softball diamonds, sand volleyball courts, and restrooms. The *park brochure* stated that it was open to the public between 7 a.m. and 10:30 p.m. "No open burning/fires are allowed in any park."

A *police report* and law enforcement officer (LEO) provided the following information:

- On March 10, 2025, at 7:54 p.m., a community person (CP) called 9-1-1 reporting a "noise complaint" or "loud bang" at the facility's address, which sounded like fireworks or gunshots and "rattled" the CP's windows and "shook" his/her house. The CP also reported hearing debris hit his/her house after the explosion. An LEO heard the explosion from seven blocks away.

- The LEO responded to the facility and met the VA and P1 in the facility's yard. The VA told the LEO that s/he was lighting "modified" fireworks and did not expect it to make such a loud noise or "blow up on the ground." The modifications included adding a towel, duct tape, and an aluminum can. The VA told the LEOs that s/he had previously received approval to light fireworks from the facility's "higher ups." The VA also told the LEOs that s/he had previously "gotten in trouble for setting off fireworks" and "for a pipe bomb incident" at his/her former home, which was "raided" by the FBI.

- The LEO checked the location of the explosion and saw pieces of metal and "a cardboard tube approximately eight to twelve inches in length that appeared to have burst and had burn marks on it." There was also a "disturbed area" on the ground "about the size of wheelbarrow and appeared to be the area where the explosion occurred." "A bluish powder substance [was] on the dirt."

- P1 told the LEO, "[The VA] sets off explosives/fireworks on a regular basis and other staff members allowed this, so [P1] allowed this." P1 said that s/he did not know what the VA was doing or what s/he used to build his/her fireworks and that P1 "wasn't paying attention to [the VA]."

- The LEOs looked inside the VA's bedroom and saw multiple unknown powders, pressure cookers, fuses, and blasting caps. The LEO sent photos of items to "the bomb squad." The bomb squad determined the items were "not illegal to have and can be purchased online." However, the way the VA was using the

items, to build homemade fireworks, was illegal. The VA did not have an active explosive or mixture of chemicals at the time and as such the bomb squad would not be responding. The LEO did not confiscate the items as they were not illegal in their current form and left them in the VA's bedroom.

- The LEO said, "Setting off such explosives was a minor crime similar to lighting off a bottle rocket." The VA was not criminally charged but issued a citation.

- A Bureau of Criminal Apprehension (BCA) Agent was called to help assess the situation. The BCA Agent issued a search warrant for the VA's electronic devices and found internet searches for fireworks, explosives, weapons of mass destruction, bombs, tactical plans, manifestos, etc. The BCA Agent also learned that the VA had been involved in several other incidents in other jurisdictions including one where s/he made a pipe bomb. "[The VA] had a pattern of concerning behaviors and [s/he] might be on a path to targeted violence."

- On March 11, 2025, P3 contacted the LEO stating that s/he had a box of the VA's "fireworks ingredients." The VA gave the items to P3 that morning and said s/he did not want to get in "anymore trouble" and asked P3 to dispose of the items. P3 turned the items into the police department for proper disposal.

- The items that law enforcement took into custody included blasting caps, fuses, and chemicals/powders that included fertilizer, aluminum flake, strontium carbonate, strontium nitrate, potassium nitrate, potassium perchlorate, sulfur, and red gum powder, all of which can be used to make fireworks, rockets, and often used in pyrotechnics.

The VA said that s/he became interested in science at a young age. About "two months ago," the VA asked P2 for permission to make fireworks at the facility and P2 said, "Yes." On March 10, 2025, the VA walked about 50 feet into the field behind the facility and set up a homemade firework and lit the fuse, which gave him/her about 40 seconds to get away. The VA watched the firework from the facility's deck. The firework did not go into the air but exploded on the ground and was "louder" than expected. The firework, itself, was about the size of a 15-ounce soup can. The VA showed the DHS investigator his/her bedroom, which included solvents, a distiller, an environmental chamber, a heat lamp, and homemade lasers. The VA attended free classes to learn laser safety.

Facility documentation and P1-P3 provided the following information:

- P1-P3 each said that the VA was "really, really smart" or "extremely intelligent." [Note: When the VA spoke with the DHS investigator, s/he shared that his/her lasers were made with "very basic multi-mode dye," and that the lasers were legal, stating, "The divergence is so bad that the optical energy density drops to safe levels over a few feet." The lasers were blue because "it's the most visible from the high back scatter from the shorter wavelength." At the time of the site visit, the VA was working on a "smaller fuser," which s/he "needed to cure some resin to set a few thermocouples in place."] P3 said that the VA was the "most intelligent" resident the facility had ever had. P2 said, "I've never met anyone as smart."

- P3 said that in October 2024, when the VA moved in, his/her family member dropped off his/her belongings at the facility. Staff did not search the belongings. The VA did not like staff going into his/her bedroom, and so staff respected his/her privacy and did not go into his/her bedroom. The VA had his/her chemicals labeled and locked in a cabinet in his/her bedroom. P1-P3 did not know the names or purposes of the chemicals.

- P3 said that in January 2025, s/he attended the VA's 45-day meeting, which included the VA, the G, the CM, the VA's family member, and another supervisory staff person (P4). During the meeting, the G and the CM stated that the VA built fireworks at his/her previous home. According to P3, "The only thing that came up was [the G] saying that if [the VA] were to make any (fireworks), [s/he] could light them off." P3 told them that the VA could not light them in town, which included the facility. An unrecalled someone in the meeting stated that "with permission," staff could bring the VA into the country to light off his/her fireworks. P3 told the DHS investigator that the VA's 45-day meeting was the sole time s/he heard anything about the VA building fireworks and was not informed of anything additional until after the incident on March 10, 2025. [Note: P3 managed the facility and several other homes operated by the same license holder. P2 managed the facility, specifically.]

- P2 said that when the VA moved in, s/he isolated in his/her bedroom and did not engage with staff much. Staff tried getting him/her to interact more and support his/her hobbies and interests. The VA liked fireworks and computers. The VA told P2 that s/he wanted to build a rocket, like a "simply, skinny rocket." The VA already had the supplies needed to build a rocket in his/her bedroom; s/he moved in with the supplies. "[The VA] was cleared to have [the supplies] when [s/he] moved in." (P2 did not state who "cleared" the VA to have the supplies.) P2 added that the VA had "some unusual hobbies" that P2 "didn't know how to handle." The VA did not talk about his/her supplies or their purpose.

- P2 said that around December 2024 or January 2025, s/he asked P3 if the VA could build a small rocket and P3 said, "Yeah, [the VA] can build a rocket." The VA then built a "small bottle rocket," and asked P2 to drive him/her to a park on the outskirts of town to shoot the rocket off. P2 did so, and afterwards the VA was "excited" and asked if P2 could take him/her to the park more often. The VA started coming out of his/her bedroom more and engaging with staff and his/her housemates. The VA was "making a lot of progress."

- P2 said that, in total, s/he drove the VA to the park three times. The first was for the small bottle rocket. The second time, the VA asked to go to the park to test his/her "rocket fuel." P2 sat in his/her car and watched the VA walk into the park's field and detonate something that made a "really big noise." However, there was "no smoke" and P2 was not concerned about it. P2 did not believe s/he told P3 about this incident. The last time P2 drove the VA to the park, the VA detonated a "bigger firework," which had "lights and stuff" and was "really loud." P2 told the VA that s/he could not build a firework bigger than that one. P2 told the VA that s/he could only shoot off smaller fireworks and maybe a bigger one every couple of months or for the Fourth of July.

- P1 said that around the beginning of February 2025, s/he asked P2 if it was okay to bring the VA to the park to light fireworks and P2 said that it was okay. According to P1, P2 said that s/he had spoken to the "parks and rec" department, who said, "It was all legal." P1 said that about two to three times, s/he drove the VA to the park to light his/her fireworks. On time, P1 drove the VA out into the country to light a firework. P1 could not recall when these instances occurred. P1 said that s/he was "not comfortable" with the VA's fireworks, but it was the VA's hobby and P1 was supposed to support the VA's hobbies and interests. At some point prior to March 10, 2025, the VA lit a firework in the facility's backyard and regarding this, P1 said, "[P2] never said, 'no,' so we (staff) don't know" what was allowed or not.

- P1 said that on March 10, 2025, around 7:30 or 8 p.m., s/he was on the deck watching the VA setup a firework in the field about 100 feet behind the facility. The VA then came onto the deck, and they watched the firework detonate. It was "really sparkly" and went up in the air about six feet and made a

"boom." "A really big bang." P1 said that in hindsight, s/he "realized [the VA's fireworks] kept getting bigger and bigger." Up until the one on March 10, 2025, the fireworks "weren't that bad." The explosions were "tiny … like sprinklers." However, the explosion on March 10 was the biggest P1 had seen produced by one of the VA's fireworks.

- P1-P3 each said that the VA rarely received packages in the mail and so they believed the VA had his/her firework making materials when s/he moved into the facility. P2 saw the VA receive maybe two packages and neither had any warning labels about what was inside. The VA opened the packages on his/her own and P2 did not know what was inside the packages. P3 said that the VA purchased things online or went to the store with staff or a family member. Staff were not documenting what the VA purchased.

- P1 said that the VA spent most of his/her time in his/her bedroom and only communicated with staff by typing on his/her cellphone. P1 tried to "touch base" with the VA once per shift. At times, the VA had various "powders" on the dining room table, but P1 had not seen him/her mixing anything. The VA's chemicals and fireworks never caused injury or property damage.

- The facility's *Internal Review* included the following interviews with P4, P5, P6, and P7:

  - P4 said that s/he "was told" the VA had chemicals in his/her bedroom, which s/he liked to experiment with. The VA made fireworks and firecrackers and P4 "thought [the VA] could set them off in the country." P4 typically found out "after the fact" when the VA set off his/her fireworks. P2 would say, "Hey. I took [the VA] out and [s/he] lit off a firecracker." "[P4] assumed [P2] had the approval" to bring the VA into the country to shoot off his/her fireworks. P4 was a supervisory staff person but P2 had been working longer at the facility than P4, and so P4 believed, "[P2] had the okay to go ahead and do that (fireworks)."

  - P5 said that P2 told him/her, "It was all preapproved – all material and supplies."

  - P6 said that one time, P1 told him/her to take the VA to the park to light a firework. P6 did so and saw the VA light, what P6 believed was, a store-bought firework. P6 did not know the firework was homemade.

  - P7 saw the VA light "little firecrackers" at the facility and at the park. The VA always wore protective gear, like an aluminum helmet.

  - The fireworks created explosions, which were "small" or "medium-sized."

  - The facility's *Shift Notes*, as recorded in the *Internal Review*, stated that between December 2024 and March 2025, the VA's use of or discussion about chemicals, lasers, rockets, smoke bombs, and fireworks were recorded 23 times by staff, including:

    - On January 24, 2025, P5 stated that the VA went outside the facility "to light [his/her] chemicals on fire," which made a "noise like a firework" and the VA "stopped *[SIC]* (the fire) out."
    - On January 25, 2025, P5 stated that the VA was at the kitchen table mixing chemicals. The VA and a housemate went outside the facility to shoot off his/her rockets, which made "three big" explosions." "Both residents stopped *[SIC]* the small fires out afterwards."

  - On February 5, 2025, P1 brought the VA to the park to shoot off three firecrackers.
  - On February 6, 2025, P1 stated that the VA detonated a few fireworks at the park and "smoke bombs" in the facility's yard.
  - On February 8, 10, 12, and 16, 2025, various staff drove the VA to the park to detonate his/her fireworks.
  - On February 25 and 27 and March 7 and 8, 2025, P7 stated that the VA "tested (unspecified) experiments" in the facility's yard. The "experiment" on March 8 was "a little loud."

- P2 said that in hindsight, s/he was "naïve." "I was very lenient. [The VA was a] different type of care than I was used to. I was very lenient. I should have looked further into things … I wasn't perfect." P2 added that no one else raised concerns to him/her about the VA's fireworks "getting out of hand." P1 once told P2 that the VA's fireworks were "very loud but not too explosive" and P1 did not express concerns about this to P2. P2 did not call "parks and rec" regarding the legality of lighting fireworks at the park.

The CM said that the VA liked experimenting and told the CM, "It was nothing that could harm people." However, "all of a sudden" the VA was "modifying fireworks" and the CM did not know the VA's experimentation had gotten "to that extent." "I don't think anyone was aware [the VA] had anything that dangerous. We all thought [the VA] had simple science experiments that used basic household chemicals." The CM first became aware the VA was making homemade fireworks following the incident on March 10, 2025. The VA preferred to be by him/herself and did not like people looking at him/her. "Supervision can be hard."

The G said that s/he had no concerns with the facility's supervision or care of the VA. The VA was "doing well" since moving into the facility. The VA had "unlimited alone time" at the facility and in the community.

Facility documentation stated that the staff interviewed for this investigation received training on the VA's support plans and the Reporting of Maltreatment of Vulnerable Adults Act. [Note: The facility's *Internal Review* provided the dates of P4's-P7's training, which included the VA's support plans and the Reporting of Maltreatment of Vulnerable Adults Act.]

Relevant Minnesota Statutes and Rules:

Minnesota Statutes section 245D.04, subdivision 3, paragraph (b), clause (9), states, in part, the license holder must ensure services were provided in a setting that is free from hazards that threaten the person's health or safety.

Minnesota Statutes section 245D.22, subdivision 2, paragraph (h), states, in part, the license holder must ensure that service sites owned or leased by the license holder are free from hazards that would threaten the health or safety of a person receiving services by ensuring the use of dangerous items or equipment by persons served by the program must be allowed in accordance with the person's support plan addendum.

Minnesota Statutes section 245D.24, subdivision 3, paragraph (f), states, in part, a person must be allowed to bring personal possessions into their bedroom and accumulate possessions to the extent the residence is able to accommodate them, unless doing so is contraindicated for the person's physical or mental health, would interfere with safety precautions or another person's use of the bedroom, or would violate a building or fire code.

Relevant Austin, MN Codes of Ordinances:

Chapter 10.04, subdivision 3 states, in part, it is unlawful for any person to fire or discharge any firecracker, skyrocket or other fireworks.

Chapter 10.04, subdivision 5 states, in part, it is unlawful for any person to possess any firecracker, skyrocket or other fireworks.

Chapter 10.04, subdivision 8, paragraph A states, in part, that fireworks any substance or combination of substances or article prepared for the purpose of producing a visible or an audible effect by combustion, explosion, deflagration, or detonation, and includes any fireworks containing any explosive or inflammable compound, or any tablets or other device containing any explosive substance and commonly used as fireworks.

Chapter 10.31, subdivision 2 states, in part, that it is unlawful for any person to make, continue or cause to be made or continued any excessive, unnecessary or unusually loud noise or any noise which either annoys, disturbs, injures or endangers the comfort, repose, health, peace or safety of others, within the city limits.

<u>Conclusion</u>:

A. Maltreatment:

It was reported that staff did not intervene when, more than once, the VA built homemade fireworks and detonated them causing "loud explosions" or "loud bangs."

Although the VA's support plans did not state if the VA was allowed to build fireworks or what staff were supposed to do regarding the VA's science experiments, the plans did state that the VA might need help avoiding "risky or ambiguous situations." If staff observed the VA mixing chemicals, they were supposed to contact the G, the CM, and the VA's family member to discuss the risk and "[illegible] to mitigate that risk in the future." The VA had a history of police involvement and getting in trouble for building "pipe bombs."

Between December 2024 and March 2025, staff documented multiple instances of the VA experimenting, detonating fireworks, and lighting chemicals on fire, which needed to be stomped out on the ground. These were violations of *Austin, MN Codes of Ordinances* and placed the VA at risk of legal consequences. P1 said that in hindsight, s/he "realized [the VA's fireworks] kept getting bigger and bigger." P2 said that in hindsight, s/he was "naïve," "I should have looked further into things," and that the VA had "some unusual hobbies" that P2 "didn't know how to handle." The VA did not talk about his/her supplies or their purpose.

A *police report* stated that on March 10, 2025, the VA detonated a modified firework that was heard from blocks away; "shook" or "rattled" neighboring houses; and had debris hit at least one nearby house. P1, who was present at the time, told the LEOs that s/he did not know and was not paying attention to what the VA was doing or using for his/her fireworks. A BCA Agent stated, "[The VA] had a pattern of concerning behaviors and [s/he] might be on a path to targeted violence."

The VA's plans stated, "[The VA] loves science and experimenting with chemicals (making/building fireworks), and lasers … [The VA] is very careful with all of [his/her] chemicals and knows which ones [s/he] can mix together." The chemicals were labeled and locked in a utility cabinet in the VA's bedroom. The VA had a fire extinguisher and baking soda in his/her bedroom for fire prevention. The plans reviewed for this investigation did not state if

the VA was allowed to build fireworks or what staff were supposed to do regarding the VA's experiments which was a violation of Minnesota Statutes section 245D.22, subdivision 2, paragraph (h).

Although staff were respecting the VA's privacy by not entering his/her bedroom, the facility was responsible for ensuring that whatever was in the VA's bedroom was not hazardous to the VA's and other residents' health and safety. When the LEO searched the VA's bedroom, they found blasting caps, fuses, and chemicals/powders that included fertilizer, aluminum flake, strontium carbonate, strontium nitrate, potassium nitrate, potassium perchlorate, sulfur, and red gum powder, all of which could be used to make fireworks and rockets and were often used in pyrotechnics, which were violations of Minnesota Statutes section 245D.04, subdivision 3, paragraph (b), clause (9); and Minnesota Statutes section 245D.24, subdivision 3, paragraph (f).

P1-P7 were aware of the VA's history and/or that the VA was currently building fireworks but did not follow-up on this information or intervene in any way or inform the CM. Although the VA was careful and knowledgeable about his/her experiments and fireworks, the VA was also creating explosives, which were illegal and placed him/herself and others at risk of serious injury. On March 10, 2025, the VA's explosive produced a noise that was heard at least seven blocks away, a "wheelbarrow" size disturbance on the ground, and debris that hit a neighboring house. In addition, staff allowed the VA to detonate his/her fireworks and complete his/her "experiments" both at the facility, which was within city-limits, and at a park, which was open to the public. Therefore, there was a preponderance of the evidence that there was a failure and omission by staff to supply the VA with care or services, which were reasonable and necessary to maintain the VA's health or safety.

It was determined that neglect occurred (the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

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

When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead agency shall consider at least the following mitigating factors:

(1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;

(2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(3) whether the facility or individual followed professional standards in exercising professional judgment.

P1-P7 were responsible for the VA's care and supervision, and received training on the VA's support plans and the Reporting of Maltreatment of Vulnerable Adults Act.

P1 and P5-P7 each provided information that they received approval or thought a supervisor was aware of and approved the VA's use of chemicals and fireworks. P2-P4 were supervisory staff persons and had some knowledge of the VA's history or current use of science experiments and fireworks. Given the violations of Minnesota Statutes and *Austin, MN Codes of Ordinances* as outlined above, and that multiple staff persons at various levels of authority failed to follow-up or intervene, it was determined that there was a systemic failure by the facility, which mitigated staff persons individual responsibility.

The facility was responsible for maltreatment of the VA.

C. Serious Maltreatment:

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

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

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

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

Action Taken by Facility:

The facility completed an *Internal Review* and determined that the VA's support plans and the facility's policies and procedures were adequate; however, unspecified policies and procedures were not followed. The facility planned to revise the VA's support plans to be "more specific that [s/he] actually likes to build fireworks." The facility planned discussions with the VA's interdisciplinary team regarding safety measures and potential rights

restrictions on purchases. The VA agreed to no longer build firework or explosive materials and to open incoming packages in front of staff.

<u>Action Taken by Department of Human Services, Office of Inspector General</u>:

On November 5, 2025, the license holder was ordered to forfeit a fine of $1000 as a result of the substantiated maltreatment for which facility was responsible. The maltreatment determination and the Order to Forfeit a Fine are each subject to appeal.