

**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:** 202505105

**Date Issued:** November 20, 2025

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive

Accurate Health Services  
4111 Central Ave. NE  
Suite 208F  
Columbia Heights, MN 55421

**License Number and Program Type:**

1096048-HCBS (Home and Community-Based Services)

**Investigator(s):**

Scott Brandt  
Minnesota Department of Human Services  
Office of Inspector General  
Licensing Division  
PO Box 64242  
Saint Paul, Minnesota 55164-0242  
651-431-6556  
scott.j.brandt@state.mn.us

**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) brought a vulnerable adult (VA), who had a history of alcohol use, to liquor stores where the VA purchased alcohol. It was also reported that the SP did not supervise the VA in the community.

**Date of Incident(s):** Prior to June 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 remotely (the VA's interview was done in person), including documentation from the facility and through five interviews conducted with the VA, the VA's case manager (CM), the VA's guardian (G), a staff person from the VA's assisted living (AL) program, and a facility management staff person (P). Although this investigator contacted the SP, the SP did not respond to requests to be interviewed.

The VA lived in a locked memory care unit at an assisted living program not licensed by the Department of Human Services. The VA received 28 hours of weekly services from the facility at the assisted living program. The 28 hours of weekly services were licensed by the Department of Human Services. The SP was the only staff person who worked with the VA and the only person, aside from the G, that took the VA into the community. When the SP worked with the VA, the SP assisted the VA with grocery shopping and accessing the community.

The VA's *Individual Abuse Prevention Plan* stated that the VA "cannot be unattended" in the community and that "staff must always be with [the VA]."

The VA's *Self-Management Assessment* showed that the VA was diagnosed with a "brain injury," seizure disorder and memory loss. The plan showed that the VA needed supervision in the community at "all times." The VA enjoyed going to parks and libraries.

A review of the VA's plans did not show any concerns related to alcohol use.

The AL provided the following information:

- On June 9, 2025, a housekeeper at the assisted living program entered the VA's unit, while the VA and the SP were in the community and found two "opened tall beer cans" and "Windsor liquor bottles." Liquor was also found in a "tumbler mug."
- When the VA and the SP returned to the assisted living program, the VA had an alcohol "impairment" and his/her "jacket appeared to be heavier on one side." The AL talked to the SP, who said that the VA "did enter liquor stores" to purchase alcohol with the VA's funds and that the SP "would wait outside." Because the VA "admitted to drinking," his/her seizure medications were held that day.
- When clients wanted to drink alcohol, the assisted living program required that the client have written authorization from his/her guardian prior to consumption of alcohol. The VA did not have guardian authorization for the VA to drink alcohol. Alcohol was not provided by the assisted living program.

The VA said that on two occasions, the SP drove the VA to a liquor store to purchase alcohol for the VA and that the SP remained outside when the VA made the purchases.

The G provided information that was consistent with the information provided by the AL, but added that in March 2025, the G became the VA's guardian. When the G was asked what information was in the VA's plans from the facility regarding the use of alcohol, the G said, "Nothing," because the G "didn't know" that the VA was

“drinking.”

The CM stated that the VA “used to be alcohol dependent,” but the CM did not know how long the VA had refrained from drinking alcohol before June 9, 2025. The CM also stated that when staff persons took the VA into the community, they needed to be with the VA “at all times.”

The P provided the following information:

- When the P was asked to provide information in terms of what was in the VA’s plans regarding alcohol use, the P stated that the plans said that the VA “may make bad decisions when it comes to alcohol,” but did not have any “restrictions” related to alcohol use.
- When the P asked the SP about supervision in the community, the SP stated that s/he was always within visual range of the VA in the community. The SP worked with the VA on June 9, 2025.

The facility’s internal review provided the following information:

- When the SP was interviewed, the SP denied taking the VA to liquor stores and denied leaving the VA unsupervised, but the SP acknowledged that the VA purchased “light beer” from a convenience store on two occasions. The SP did not observe any “misuse or intoxication.”
- When the VA was interviewed, the VA initially stated that the SP did not take the VA to liquor stores and “claimed” that the VA “went alone.” Later in the interview, the VA “changed” his/her “story” and said that the SP took the VA to liquor stores. The VA also said, “We are always together” when asked about the supervision the SP provided.

The facility’s training records showed that the P and the SP were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the VA’s care plans prior to June 9, 2025.

### **Conclusion:**

On June 9, 2025, the SP and the VA went into the community. While they were gone, a housekeeper at the VA’s assisted living program found alcohol in the VA’s unit. When the VA and the SP returned, the AL noted that the VA had an alcohol “impairment.” The SP, who did not provide information to this investigator, told the AL that the VA purchased alcohol while the SP remained outside the store, which conflicted with the VA’s plans that the VA always needed supervision. When the SP was interviewed for the facility’s internal review, the SP denied taking the VA to liquor stores and denied leaving the VA unsupervised but stated that the VA bought “light beer” from a convenience store on two occasions. Although the VA stated that the SP remained outside the store when the VA purchased alcohol, the VA stated, “We are always together” when the facility conducted its investigation.

Although the SP provided inconsistent information whether s/he did not supervise the VA in the community when the VA purchased alcohol, given that the VA stated they were always together and also provided inconsistent information regarding the alcohol purchase, that the VA’s plans did not say the VA could not purchase alcohol, and that there was no information that the VA was harmed, there was not a preponderance of the evidence whether there was a failure to provide the VA with 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).

**Action Taken by Facility:**

The facility completed an internal review and determined that policies and procedures were adequate, followed and that no additional training was provided.

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

No action taken.