

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: 202408517

Date Issued: November 19, 2025

Name and Address of Facility Investigated:

Jobs House of Prosperity
14703 Dunbar Court
Apple Valley, MN 55124

Jobs House of Prosperity
7581 9th St N Suite 100
Oakdale, MN 55128

Disposition: Substantiated as to physical and emotional abuse and neglect of a vulnerable adult by three staff persons.

License Number and Program Type:

1125078-H_CRS (Home and Community-Based Services-Community Residential Setting)
1103884-HCBS (Home and Community-Based Services)

Investigator(s):

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Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
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Suspected Maltreatment Reported:

It was reported that two staff persons (SP1 and SP2) used two "unnecessary" restraints/holds on a vulnerable adult (VA). During the incident, SP1, SP2 and another staff person (SP3) "argued with, engaged in power struggles with, taunted/mockered, and laughed at" the VA and SP1 put an object in the VA's mouth when s/he cried. SP3 put his/her hands down his/her pants, pulled them out, and put them towards the VA's face and told the VA to "smell it;" and pushed the VA up against a wall and "whipped" the VA's legs with his/her phone charger cable. The VA put a sweatshirt belonging to SP3 in the trash and SP3 removed it and wiped it on the VA's head. The facility had video camera footage of the 90-minute span during which this occurred.

Date of Incident(s): September 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 October 9, 2024; from documentation at the facility and law enforcement records; and through four interviews conducted with a facility supervisor (P1), the VA's guardian (G), the VA, and SP2. SP1 was contacted and declined to provide information regarding the report to DHS and law enforcement. Attempts were made via phone and certified mail to contact and interview SP3, but SP3 did not respond to the requests. The interviews were conducted in conjunction with a law enforcement officer (LEO) who was also investigating this report.

The VA was diagnosed with borderline personality disorder, autism spectrum disorder, schizoaffective disorder, and posttraumatic stress disorder and lived at the facility since July 31, 2024. The VA enjoyed shopping, going to the gym, writing his/her own songs, and doing pottery.

The VA's *Community Support Plan (CSP)* provided the following information:

. . . On a bad day [the VA] will isolate [him/herself], gets angry, and lashes out. . . .

[The VA] doesn't share [his/her] talents because [s/he] doesn't want to feel judged. . . . [The VA] lives alone in a house with 2:1 staffing. . . . It is important to [the VA to] receive cues and encouragement . . . particularly when [s/he's] struggling with [his/her] emotions and behaviors. . . .

[The VA] has a long history of mental health and behavioral issues . . . [The VA] has physical aggression towards others which includes biting, kicking, hitting, punching, scratching, head butting, charging, posturing, grabbing at staff and/or their badges, and blocking/preventing staff from leaving the area.

The VA's *Individual Abuse Prevention Plan (IAPP)* stated that the VA was susceptible to physical abuse. The VA was unable to identify potentially dangerous situations, was unable to deal with verbally/physically aggressive persons, and was verbally/physically aggressive towards others. "All staff are trained in maltreatment of

vulnerable adults and will ensure the health and safety of [the VA]. If staff suspect that [the VA] has been physically abused, staff will ensure [his/her] health and safety and notify [his/her] team as well as notify the local police department and notify MAARC [Minnesota Adult Abuse Reporting Center]." The VA also had a history of suicidal attempts and ideations.

The VA's *Support Plan Addendum-Intensive Services* provided information that was consistent with the information in the *CSP* and *IAPP* and the following additional information:

- [The VA] will need assistance with regulating behaviors that may lead to choking. [The VA] historically will wrap things around [his/her] neck that may cause choking. Staff will assist [the VA] and redirect [him/her] when [s/he] has behaviors that include choking.
- Staff will be aware of sensory triggers for [the VA] and assure that noises are kept to a minimum and inside voices are used at all times in the home.
- Staff will assist [the VA] with reducing emotional dysregulation in the moment using positive self-management skill with [the VA] when possible and safe to do so.
- Staff will ensure that they are working with [the VA] on better coping skills and ways to help redirect [his/her] behaviors when [s/he] is becoming dysregulated. Staff will use redirection and offer alternatives for [the VA] when [s/he] is becoming dysregulated and use lowered voices when addressing concerns or issues with [the VA].
- Staff will assist with managing dysregulations and offer other choices to keep [the VA] engaged to reduce property destruction.
- Staff will redirect [the VA's self-injurious] behavior by offering person centered activities for [the VA] to engage in and be aware of symptoms and increase in behaviors.

The VA provided the following information:

- On September 27, 2024, SP1-SP3 were working. The VA initially stated that s/he did not want to provide additional information because s/he did not want SP3 to "get in trouble." The VA later stated that SP3 hit him/her on the upper thigh with a cord. The VA showed a mark that was horizontal across the back of the VA's leg that appeared fainter than in the video recorded 13 days prior. The VA identified P1 and SP3 as two of his/her favorite staff persons at the facility.
- Regarding the other incidents the same day, when asked if any liquid was poured or applied onto his/her body, s/he stated that SP1 and SP3 put alcohol and peroxide on him/her. When the VA attempted to take off his/her shirt, SP1 and SP2 "restrained" him/her. The VA put SP3's sweatshirt in the garbage, so SP3 removed it from the trash can and put it on the VA'S head. SP3 also put his/her hands down his/her pants and then put his/her hands in the VA's face.

The G stated that /she was aware of the incident but s/he did not have additional specific information to provide. The G added that because the VA had a history of providing false information and "embellishing" stories, the facility had cameras to confirm whether what the VA said was true.

Video footage from September 27, 2024, that was seven hours long was provided to law enforcement. The DHS investigator watched portions of video footage, as did law enforcement, and each took minute-by-minute notes, information from those notes, the *Behavior Incident Reporting Forms* and *Incident Reports* provided the following consistent information:

- At 4:05 p.m. SP1-SP3 and the VA were outside and the VA could be heard yelling for help. There were no cameras outside the facility. At 4:16 p.m. SP3 was inside sitting on the couch, and the VA can be heard outside screaming and crying, "Somebody help me," and "You are hurting me." [Note: Based on the VA's volume and because the indoor security cameras picked up the sound, SP3 would have been able to hear the VA screaming.]
- At 4:18:40 p.m. the VA and SP3 were in the kitchen, the VA hit a window and SP3 stated, "I dare you." SP2 then attempted to restrain the VA stating, "Quit fucking fighting me." SP3 then assisted SP2 and pushed the VA into the kitchen cabinets. The VA began to cry and SP2 told the VA to stop crying and, "Sit the fuck down." SP2 and SP3 then let go of the VA and the VA walked away into the living room and grabbed his/her left forearm as if it were injured. SP2 and SP3 followed the VA and the VA spit on them, to which SP3 said, "The next time you do it, it will go all over your fucking face." The VA told staff persons that they injured him/her but they did not check the VA for injuries.
- At 4:25 p.m. SP3 told the VA, "I'm gonna dig in my ass and wipe it on your nose." SP3 then placed his/her right arm into the back side of his/her pants, underneath his/her clothing, and then wiped his/her hand in the VA's face as the VA tried to cover his/her face with his/her hands. The VA backed away from SP3, but SP3 continued to put his/her hand in the VA's face saying, "Smell it." While this was occurring, SP1 and SP2 were sitting at a table watching and laughing.
- The VA then approached SP3 and SP3 put his/her right hand in the back of his/her pants, underneath his/her clothing, removed it, and put it in the VA's face. The VA then tried to grab SP3's phone but was unsuccessful. SP3 set down the phone and the two began "play fighting" by swinging their arms at one another. The VA then picked up SP3's cell phone and SP3 pushed the VA up against a wall. SP3 said, "Let it go," which the VA did and SP3 walked away towards the couch.
- SP3 tried to pick up a phone charging cable off the floor, but the VA stepped on it to prevent SP3 from picking it up. SP3 told the VA, "Get off the charger," and the VA did. The VA then walked past SP3 and stomped on SP3's ankle. In response, SP3 picked up the charging cord and hit the VA on the back with the cord. SP2 and SP3 laughed at the VA and SP2 asked, "You ever been hit with a switch?" SP3 then attempted to hit the VA with the cord at least four additional times but missed. The VA went into the kitchen and stood by SP1 and SP2 at the table and SP3 stated, "I beat you," and "I won, and you are a loser."
- At 4:30 p.m. the VA walked towards SP3, and SP3 attempted to hit the VA again with the cord, once unsuccessfully but then hit the VA's left leg. After the cable struck the VA's back of the left upper leg there was a red mark left on the VA's leg. The VA walked to a couch in the living room, sat down, and cried. When the VA got up, walked towards SP3 who was sitting in the living room on another couch and attempted to hit SP3 with a pillow but SP3 blocked the hit. SP1 and SP2 were still sitting at the table and laughing. The VA then went and lay on the couch and was crying in pain.

- At 4:32 p.m. SP3 stood up from the couch, walked towards the VA, lifted his/her foot, and stepped on the VA's ankle appearing to apply pressure. As the VA cried, SP3 stood above the VA then stopped stepping on the VA's ankle, walked away, and said, "It doesn't hurt."
- At 4:36 p.m. the VA stood up from the couch, went over to SP3 who was sitting on another couch, and stepped on SP3's foot. The VA then took SP3's sweatshirt off of the table and put it in the kitchen trash can. SP3 stood up from the couch, said, "Damn [n-word, racial slur]," walked to the trash can, removed his/her sweatshirt, and pushed it into the VA's face. The VA then grabbed SP3's phone and SP3 backed the VA into a wall. SP3 stood in front of the VA and yelled at the VA to give him/her the phone and held the cable in a manner that appeared s/he was threatening to hit the VA with the cord. SP3 started swinging the phone cord at the VA, hit the VA repeatedly on his/her arms until the VA gave SP3 his/her phone back.
- At 4:37 p.m. the VA took some items belonging to SP2 and SP2 then began moving his/her other items to prevent the VA from taking them. The VA tried to take more items from SP2, and SP2 said, "You better back the fuck up." As the VA walked away from SP2, s/he tried to kick SP3 and then SP3 tried to step on the VA's feet.
- At 4:40 p.m. the VA began to take off his/her shirt and SP1 and SP2 began to restrain the VA by holding the VA's wrists to keep his/her shirt down. The VA spit at SP2, so SP1 put his/her hand and a piece of his/her scarf s/he was wearing over the VA's mouth. SP1 and SP2 then forced the VA's arms through the armholes of his/her shirt and held the VA like that until 4:41:30 p.m. when SP1 and SP2 let the VA go. During the entire time, the VA screamed and cried and SP3 was seated next to the VA doing something on his/her phone.
- At 4:49 p.m. SP1, SP3, and the VA were in the living room when SP2 came into the living room carrying a container of rubbing alcohol. The VA told SP2 not to put rubbing alcohol on him/her, but SP2 proceeded to pour rubbing alcohol on a wound on the VA's lower right calf. The VA then began screaming. SP2 then poured rubbing alcohol on the VA's left arm while SP1 held the VA's arm down. The VA then rubbed the wound area on his/her lower right calf on the couch so SP2 poured more rubbing alcohol onto the wound while the VA screamed saying, "Stop." SP2 and SP3 both told the VA they were helping him/her and SP1 and SP2 laughed at the VA.
- At 4:52 p.m. SP2 asked the VA if s/he wanted hydrogen peroxide on his/her wound and the VA did not respond. SP2 told the VA, "You're gonna like it," and discussed with SP1 and SP3 about cleaning the VA's wound with hydrogen peroxide. SP1 then left to get the hydrogen peroxide.
- At 4:53:59 p.m. SP1-SP3 cornered the VA in a small area of the kitchen and the VA began to scream at them. The VA then took SP3's charging cable, put it around his/her neck, and tightened it. The VA then removed the cord from his/her neck and threatened to hit staff persons with the cord, so SP2 pushed the VA into the living room onto a couch.
- At 4:55:21 p.m. as the VA was on his/her back on the couch, SP2 held him/her down as SP1 poured hydrogen peroxide onto his/her arms and legs. As SP2 held the VA down on the couch, SP2 asked the VA, "Are you done?" and "Want some more?" The VA responded, "No." SP1 then asked the VA multiple more times if s/he was "done" as s/he poured more hydrogen peroxide onto the VA's leg wound.

- At 4:58 p.m. the VA tried to wrap the phone cord around his/her neck. SP2 said to the VA, "You want to do it again? We're trying to save you from yourself." The VA then removed the cord from his/her neck.
- At 5:01:25 p.m. the VA walked to a couch, started spitting, and removed his/her shirt. SP1 grabbed the VA's hands and SP2 put the VA's shirt back on. SP1 and SP2 then restrained the VA on the couch while the VA "screamed and appeared in pain." SP1 and SP2 "eventually" let go of the VA. SP3 was sitting on the couch doing something on his/her phone while SP1 and SP2 were restraining the VA. The VA said, "you're all going to jail," and SP1-SP3 each laughed.
- At 5:07 p.m. the VA took a shower and at 5:12 p.m. s/he exited the bathroom wearing only a towel. SP1, SP2, and the VA went into a bedroom that was out of view of any cameras. The VA said, "I don't want those clothes," and SP1 or SP2 replied "I don't care," and then there were sounds of a struggle. At 5:17 p.m. the VA exited the bedroom clothed with SP2 and SP2 said, "You look cute in your little onesie," and the VA replied, "shut up."
- At 5:18 p.m. the VA asked SP3 to place a call for him/her and at 5:22 p.m. SP3 placed the call. The VA told the person on the phone (determined to be P1) that the staff persons held him/her down and poured alcohol "all over" his/her body, choked him/her, and hit him/her with a phone cord across his/her back and legs. The call ended at 5:50 p.m.

SP2 provided the following information:

- SP2 watched the video camera footage from September 27, 2024, and stated that s/he would "fire [him/herself]" and that s/he "owned up to everything." SP2 added that "all hell would break loose" if someone treated his/her family member the way that s/he treated the VA that day. SP2 stated there was "no explanation" for his/her actions.
- SP2 primarily worked at another residential program operated by the same license holder and September 27, 2025, was the first day SP2 ever worked with the VA. Around 1 p.m., the VA tried to leave out of a gate in the backyard. A supervisory staff person (P2) told SP2 that s/he could not let the VA out of the gate and if s/he needed, SP2 was to restrain the VA and then assist the VA back into the facility. SP2 stated that P2 told him/her that the VA needed to have a shirt on "at all times," and "by any means necessary." SP2 did not know that holding the VA's wrist was an "improper restraint," and that s/he was more so trying to hold the VA's hand.
- SP2 stated that s/he did not intervene when s/he saw SP3 hit the VA with the phone cord or when SP1 put his/her scarf on the VA's face. SP2 was trained that if s/he saw a staff person treating a client as observed to intervene and report what occurred to P2. SP2 added that "in hindsight" s/he should have called P2 for help.
- SP2 stated that s/he was not trained on first aid by the facility, but that s/he "knew" alcohol disinfected and hydrogen peroxide cleaned wounds. SP2 stated that s/he "usually" would have used napkins, but did not have any, so s/he "poured" alcohol and hydrogen peroxide on the VA's wound. Later in the day, SP2 "leaned over" while the VA was crying and asked, "You want more?" SP2 stated at that time s/he was asking if the VA needed additional medical attention and did not consider his/her actions of pouring alcohol and hydrogen peroxide on the VA's wound to cause pain because s/he was disinfecting the wound. Regarding injuries, s/he noted that the VA's left leg was "a little red."

- [Note: Information provided by the facility showed many hours of training, however SP2 stated that “[facility administrative staff] made us sign that the day we watched the video” regarding the incident on September 27, 2025. SP2’s training file showed that s/he received supervised training at the facility on August 21 and 31 and September 23, 2024. SP2’s training file also showed that s/he was trained on bloodborne pathogens and basic first aid and indicated that s/he read the employee handbook; SP2 stated that s/he received no training and signed that s/he read the handbook but did not.]

P1 provided the following information:

- On September 27, 2024, SP1-SP3 were working. P1 stated that s/he watched video footage from that day and heard the VA screaming from outside the facility, which was not visible by a camera. The first appearance of the VA in the video was when s/he walked down the facility hallway. Later in the video, P1 saw SP1 and SP2 implement three “improper” restraints on the VA. SP3 was not involved in any of the restraints.
- At times, the VA takes off his/her clothes and staff are supposed to allow the VA to do so. If the VA was sitting or lying down the staff persons were not to “put hands on” or restrain the VA in any way. Staff persons should cover the VA with the nearest blanket or use his/her clothes so that s/he was not “exposed.” In the video, SP1 and SP2 both grabbed the VA’s wrists to prevent him/her from taking off his/her clothes. P1 stated that was not what SP1 and SP2 should have done and not what they were trained to do.
- P1 was new to the facility and only worked at the facility for “a few days” at the time of the incident. Staff persons first day of training after being hired included first aid which was taught by a facility nurse. P1 did not know the specifics of the training but knew that they were trained on how to use hydrogen peroxide and isopropyl alcohol when administering first aid.
- P1 stated that staff persons should not be on their phones “at all” while working with a client with “high needs” such as the VA. After the incident, P1 implemented a policy requiring staff persons to put their phones away in a locked box when they worked.

A law enforcement report provided the following information:

- On September 27, 2024, at 6:51 p.m. the VA requested to talk to P1 on the phone. SP3 called P1 and put him/her on speakerphone; the VA told P1 that staff persons poured alcohol and peroxide on his/her body and that SP3 hit him/her with a phone cord. SP1-SP3 “joined in” on the phone call which turned into a “yelling match” between the VA and SP1-SP3. P1 knew that SP1-SP3 were each involved, did not make a MAARC report, and allowed SP1-SP3 to continue working with the VA over the weekend.
- SP1-SP3 were each charged with criminal abuse, criminal neglect -vulnerable adult intentionally neglects or knowingly permits conditions to exist, and failure to report maltreatment. SP3 was also charged with fourth degree assault and P1 was charged with failure to report maltreatment. [Note: At the time of this report criminal proceedings were pending.]

The facility's training regarding first aid stated that after washing hands and applying latex gloves, clean the wound and surrounding area with soap and water or antiseptic. However, it further stated, "Ensure the antiseptic does not get in the wound!"

According to WebMD, "using hydrogen peroxide or rubbing alcohol to clean an injury can actually harm the tissue and delay healing."

Information provided by the facility showed that SP1-SP3 and P1 each received training on first aid and were trained on the Reporting of Maltreatment of Vulnerable Adults Act and on the VA's plans prior to the incident. Additionally, SP3 received disciplinary action in August 2024 related to "unprofessional" conduct with the VA that included verbal aggression.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245D.07, subdivision 1a states in part that the license holder must provide services in response to the person's identified needs, interests, preferences and desired outcomes as specified in the support plan and support plan addendum and in compliance with this chapter.

Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clauses (3), (4), (6) states in part that a person's protection related rights include the right to:

- Be free from maltreatment;
- Be free from restraint except for emergency use of manual restraint to protect the person from imminent danger to self or others; and
- Be treated with courtesy and respect

Conclusion:

A. Maltreatment

Regarding Physical and Emotional Abuse

Video footage dated September 27, 2024, provided by the facility and reviewed by law enforcement was seven hours long and showed SP1, SP2, and SP3 engaged in non-therapeutic and non-accidental interactions with the VA that included:

- SP1 and SP2 used at least two restraints on the VA when the VA was not a danger to him/herself or others. During these restraints, SP1 and SP2 caused the VA pain as the VA was seen crying and screaming. At one point, SP1 put his/her scarf in the VA's mouth while the VA screamed.
- SP1, SP2, and/or SP3 poured hydrogen peroxide and rubbing alcohol on the VA's back, arm, and leg wounds causing the VA to scream and cry while saying, "Stop." During this time SP1 and SP2 laughed at the VA. The facility's training on first aid, for which SP1, SP2, and SP3 were each trained stated that "using hydrogen peroxide or rubbing alcohol to clean an injury can actually harm the tissue and delay healing."
- SP3 put his/her hand down the backside of his/her pants, underneath his/her clothing and when s/he

took it out s/he put his/her hands into the face of the VA telling the VA to “smell it.” SP1 and SP2 watched the interaction, did not intervene, and laughed.

- When the VA put SP3’s sweatshirt in the trash can, SP3 took the sweatshirt out of the garbage and put it on the VA’s face.
- SP3 hit the VA with a charging cord multiple times on his/her back and his/her left leg causing marks. A horizontal mark going horizontally across the VA’s left upper leg was visible immediately in the video footage and was seen by the DHS investigator and law enforcement 13 days later. SP1 and SP2 watched the interaction and did not intervene. SP2 laughed and asked the VA, “Have you ever been hit with a switch?” and SP3 told the VA, “I beat you,” and “I won, and you are a loser.”
- Twice SP3 stepped on the VA’s ankle and appeared to apply pressure. On one occasion, it made the VA cry. The second time, SP3 told the VA, “It doesn’t hurt.”
- Throughout videos, SP1-SP3 spoke to the VA in a threatening manner, used swear words including a racially derogatory term, and called the VA “cute” in a manner that was likely condescending because the VA told them to “shut up” after it was said.
- At no time were SP1, SP2, or SP3 seen or heard attempting to implement the VA’s redirection, de-escalation, or coping strategies as outlined in the VA’s *CSP, IAPP, or Support Plan Addendum-Intensive Services*.

SP1 and SP3 did not provide information for this report. SP2 stated that s/he “owned up to everything,” that there was “no explanation” for how s/he treated the VA, that s/he would “fire [him/herself],” and that “all hell would break loose” if someone treated his/her family member the way that s/he treated the VA that day.

Given SP1’s, SP2’s, and SP3’s verbal and physical interactions with the VA as observed in the video and that the VA sustained marks from being hit with the phone cord, there was a preponderance of the evidence that staff persons engaged in conduct that was not accidental or therapeutic and produced and could reasonably be expected to produce physical pain and injury and emotional distress.

It was determined that physical and 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 hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult; and 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.

Regarding Neglect

During the video, as SP1, SP2, and SP3 engaged in the interactions towards the VA as outlined above, neither SP1, SP2, nor SP3 intervened or tried to stop the other from engaging in the physical and verbal aggressions towards the VA. In addition, at no time were SP1, SP2, or SP3 seen or heard attempting to implement the VA’s redirection, de-escalation, or coping strategies as outlined in the VA’s *CSP, IAPP, or Support Plan Addendum-Intensive Services*. Therefore, there was a preponderance of the evidence that there was a failure to supply the VA with care or services which was reasonable and necessary to maintain the VA’s health and 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.

SP1, SP2, and SP3 were each responsible for the care of the VA at the time of the incident. Although SP2 stated that s/he received no training and signed that s/he read the handbook but did not, information provided by the facility showed that SP1-SP3 each were trained on the Reporting of Maltreatment of Vulnerable Adults Act, the VA's plans, and first aid prior to the incident. In addition, SP2 stated that s/he "owned up to everything," that there was "no explanation" for how s/he treated the VA, that s/he would "fire [him/herself]," and that "all hell would break loose" if someone treated his/her family member the way that s/he treated the VA that day.

SP1, SP2, and SP3 were each 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 physical and emotional abuse and neglect for which SP1, SP2, and SP3 were each responsible was recurring and serious. SP1, SP2, and SP3 each physically abused, emotionally abuse, and neglected the VA; each did not intervene during any of the others' incidents; and although the VA did not require the care of a physician, the VA sustained injuries including tissue damage.

SP1 and SP2 were disqualified from providing direct contact services. (Regarding SP3-See Action Taken by Department of Human Services, Office of Inspector General.)

Action Taken by Facility:

The facility completed an internal review and found that policies and procedures were adequate but not followed. SP1-SP3 no longer worked at the facility.

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

SP1 and SP2 were each 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 SP1 and SP2 were responsible for maltreatment and the disqualification of SP1 and SP2 are each subject to appeal.

SP3 was notified that s/he was responsible for recurring and serious maltreatment and that any future background studies for facilities, 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, will result in his/her disqualification. The determination that SP3 was responsible for maltreatment is subject to appeal.

Minnesota Statutes, section 626.557, subdivision 3, requires mandated reporters at a facility to immediately report suspected maltreatment. The investigation determined that one individual failed to suspect reported maltreatment as required. A letter from DHS was sent to the individual regarding failure to report maltreatment and potential consequences for future such failures.

On November 19, 2025, the facility was issued a \$200 fine for failing to report maltreatment as required. The Order to Forfeit a Fine is subject to appeal.