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: 202505074

Date Issued: December 8, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

Dungarvin Minnesota LLC
28100 Newberry Trail
Lindstrom, MN 55045

Dungarvin Minnesota LLC
1440 Northland Drive Ste 100
Mendota Heights, MN 55120

License Number and Program Type:

1120656-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070806-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 a staff person (SP) drove a vulnerable adult (VA) to the VA's friends' house, left the VA unsupervised, and that the VA obtained and used methamphetamines.

Date of Incident(s): May 31, 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 was obtained during a site visit conducted on June 25, 2025; from documentation at the facility; and through seven interviews conducted with two supervisory facility staff persons (P1 and P2), two facility staff persons (P3 and P4), the VA's case manager (CM), the VA, and the SP. A law enforcement officer (LEO) also investigated this report and conducted interviews with this investigator.

The VA's plans stated the VA was diagnosed with post-traumatic stress disorder, schizoaffective disorder (bipolar type), and a stimulant use disorder specific to methamphetamine use. The VA enjoyed watching TV, going shopping, and playing video games. The VA's plans stated that s/he at times had "impulsive and unpredictable" behaviors. The VA was not subject to guardianship and had no unsupervised time in the community.

P1 provided the following information:

- On June 1, 2025, P3 called P1 to let him/her know that the VA had been unsupervised the day prior while on an outing with the SP. Initially, the VA had a planned outing to get some money from a family member. When the SP drove the VA to the planned location, the VA told the SP that the family member was actually at the VA's parents' home in Duluth, which was approximately 75 miles away from the location of the planned outing.

- The VA provided the SP an address and once the SP arrived at the home in Duluth, the VA and the SP approached the home together. The VA told the SP that s/he was going to go inside for ten minutes to grab the money and come back out. The SP waited in the car and the VA came out a half an hour later. Then they left and went back to the facility.

- The VA had a history of drug use and when the VA returned to the facility, based on some "behaviors," staff persons felt that s/he might have had access to "drugs." P3 found a "meth pipe" and threw it away before P1 saw it so P1 was unaware if it was a "meth pipe" or "marijuana pipe," and did not know when P3 found it.

- The VA was a "little bit of a manipulator" and P1 could "see" how the VA could have been "manipulative" toward the SP. The SP was new and was filling in at the facility. Had the VA been left with family members, that would have been "okay," but staff persons learned, after the fact, that the VA was not visiting family members.

- The SP told P1 that s/he was not aware of the VA having no unsupervised time in the community but also stated that s/he thought it was "okay" because the VA said s/he was visiting his/her parents. The SP said that the VA was without the SP's supervision for half an hour. The SP was "fully aware" that s/he was supposed to "understand" the VA's plans.

- The VA could provide information but would maybe go off-topic. P1 was unable to get any information about the Duluth trip from the VA as the VA's behaviors were "a little out of hand," including "cursing,"

and the VA was not "responsive to conversation." Normally P1 could talk to the VA, but the "adverse behaviors" lasted approximately four days. Several days later, the VA was "fine" to P1 when they spoke. The VA was not hospitalized or seen by a doctor afterward for this.

P3 provided the following information:

- On May 31, 2025, at about 12:45 p.m., P3 received a phone call from the SP, who asked about the VA's planned outing. P3, who reviewed all outing requests, told the SP that the VA was approved to go to Hinckley McDonald's for a four-hour outing. Two of the hours would be drive time and the other two would be to spend with a friend who P3 knew the VA referred to as a family member. That was the last that P3 heard about the outing at that time.

- On June 9, 2025, P3 was talking to the VA who told P3 that s/he had visited two individuals in Duluth that were not blood relatives, and the VA was not supervised by the SP when s/he was with them. The VA's plan did not state anything specific about who was considered family. P3 asked the SP about it and the SP said that s/he walked the VA to the door and saw two individuals that s/he thought were the VA's parents. The SP said that the VA and family were smoking cigarettes so the SP did not go inside the house. The SP took the VA at "face value" and thought that the VA was visiting his/her parents. The VA gave P3 conflicting information regarding how long the VA was inside the house, and the answers varied anywhere from 30 to 45 to 60 minutes. The SP stated that they left Duluth after about two hours which "did not compute" to P3.

- During this visit, P3 guessed the VA was able to "obtain methamphetamines" and a "meth pipe." When the VA used methamphetamines, his/her "whole demeanor changed" and s/he would go into "psychosis." For two to three days after this, the VA did not eat, drink, or sleep. On June 2, 2025, at approximately 7:25 a.m., the VA finally fell asleep and P3 went in to give medications and found a "meth pipe" half-under the VA's pillow with a "substance pooled at the bottom." The VA was still sleeping and did not know that P3 found the "meth pipe." The VA had not seemed to notice that P3 took it and had not made mention of it.

- P3 had previously found a "meth pipe" in the VA's room in April 2025, that was removed and disposed of.

- When P3 was reading General Event Reports (GERs) and Therap Logs (T-Logs), there were "reports of possible drug use."

- The VA had no unsupervised time in the community, but since s/he was his/her own guardian, s/he could be with his/her family. However, the VA was not with his/her family when the SP took him/her to Duluth. Family needed to be "blood relation." P3 had spoken with the VA on June 9, 2025, and learned that the VA had not gone to visit blood relatives but rather, friends, whom s/he named to P3.

- P3 trained the SP on the VA's plans. If P3 had accompanied the VA on his/her outing to McDonald's, P3 would have sat in the booth behind the VA while s/he met with a family member or friend to keep visual supervision on the VA.

- The VA was "very respon[sive]" when people would not "pry" and when s/he was not "under duress" from mental health issues, the information provided by the VA was "remarkable" and "very respondent."

P4 provided the following information:

- Several weeks earlier, the SP was supposed to take the VA to Hinckley, which was a pre-approved visit by staff persons to visit a family member to collect some money but instead the SP took the VA to Duluth to see a family member. Planned outings were scheduled in advance as to not interfere with any other facility clients. A change to the approved outing meant that the VA no longer got to go on his/her outing. P4 noticed that the SP did not bring any of the VA's scheduled medications with on the outing and that the VA would be gone during the timeframe in which s/he could take the medications. (Investigator note: Information showed that when the VA returned to the facility, s/he received his/her medications.)

- P4 did not know what the SP "thought was okay" regarding changing the outing plan. When P4 spoke with P3, the only outing that P3 approved was the Hinckley trip.

- The SP and the VA returned close to 8 p.m. When they arrived back at the facility, the VA was "very, very manic," and staff persons could not get him/her to "focus." The VA was acting energetic, was talking fast, and then got "very angry" and began to "see things." P4 stated that the VA was "amped up and still coming down." The VA, in general, was otherwise, "fairly mellow."

- The VA's behavior was consistent with another time when P3 located a "meth pipe" next to the VA.

- P4 would have stayed with the VA if s/he had taken him/her out for the outing or would have sat in a booth directly behind the VA so that P4 could hear and see "everything." All staff persons had access to the VA's plans and if the VA had unsupervised time. In a "generalized situation," if a client wanted to go out without staff persons, it had to be with a parent or immediate family, but P4 did not think that this was "written" anywhere. The people that the VA went to visit were not the VA's immediate family members.

- The VA could be "very good" at communicating and was a good advocate for him/herself if the VA was focused on conversation.

The VA provided the following information:

- The SP and the VA were originally going to do an outing to Hinckley so that the VA could meet a family member. The VA thought that s/he could be unsupervised by staff persons when with family members. The VA stated that s/he was visiting a family member.

- The VA denied being "high off meth" because s/he would have been "fucked up" in the vehicle, but instead, it was a "very quiet ride" with the SP up to Duluth. The VA stated that when s/he got back to the facility, s/he "got nervous" to "overprotect" him/herself. The VA denied bringing "meth" back from Duluth and stated that s/he "wouldn't even know" if a staff person found a "pipe" in his/her belongings.

P2 provided the following information:

- P2 was not working the day of the incident or for several weeks after. P2 did not have much information to provide about the incident but said that s/he heard that the SP brought the VA to Hinckley for an outing, but then the VA requested to go to Duluth to see family members. The VA told the SP that s/he was seeing a family member and went into the house on his/her own. P2 heard that the VA was "gone for a few hours" and it was believed that s/he came back with "meth." A "meth pipe" was located in the VA's bedroom on June 3, 2025.

- There had been a history of drug use during the time the VA was at the facility. One of these times, when it was believed that the VA had access to drugs, the VA's "paranoia" began to escalate, and s/he was not speaking or eating. On a previous date, the VA "relapsed" and P3 found a "meth pipe."

The CM provided the following information:

- The CM heard recent concerns about the VA saying s/he would be meeting family in Duluth, but it was not family that the VA met with. During a June 24, 2025, team meeting, the CM heard that the SP brought the VA up to Duluth to visit family and gave the VA "privacy." The VA would have had an opportunity to purchase or exchange items for methamphetamines. The CM heard that after the Duluth trip, the VA was "acting consistent" with how the VA acted when using methamphetamines regarding the behavior change and drug paraphernalia was found in the VA's bedroom.

- The VA would get methamphetamines from friends.

- In the VA's culture, s/he referred to non-blood family members as family.

The SP provided the following information:

- The SP provided inconsistent information regarding the timing of how long they were in Duluth at the residence, what time they left, and what time they arrived back at the facility.

- On the day of the incident, when the SP arrived at the facility, there was a scheduling conflict with the VA's outing and another client's outing which was scheduled earlier in the day. The VA was upset at the delay in his/her own planned outing. When the other client returned, the SP and the VA left for the outing. The outing location, McDonald's in Hinckley, was written on an outing request form, but at the time of the interview, the SP could not recall where they were originally going. When they got in the car, the VA told the SP that P3 had approved the outing to Duluth. The SP called P3 on speaker phone and they told P3 that the VA changed his/her mind about where s/he wanted to go on the outing. The VA was "financially constrained" and said s/he had loaned a family member money and needed to go to Duluth to collect the money. P3 "changed the rules" but was in a supervisory role and told the SP to take the VA to Duluth, so the SP took the VA to Duluth.

- At the time they left the facility, the SP had taken the noon medications for the VA and had administered them on time, but did not document it in the Medication Administration Record (MAR), but no other medications were brought along. A GER written by the SP later showed that the SP said that s/he took

some medications along and they were taken on the return part of the trip at a gas station. The SP did not know when they left how long they would be gone.

- The SP and the VA arrived at the house in Duluth at about 3:32 p.m. The VA asked the SP to stay in the car and got out to knock on the front door. No one answered, and the VA sat back down in the car. The VA then asked the SP if s/he could use the SP's phone. The VA called his/her apparent family member, but no one answered so the VA began to text the person on the SP's phone.

- In text messages sent by the VA to his/her alleged family member, the VA referred to the SP as his/her "Uber driver" and said that s/he had a limited amount of time there.

- The SP and the VA waited approximately one or two hours until people showed up at the house. The SP went with the VA up to the front of the residence and the VA stepped inside. The SP stayed outside because the two persons said to be the VA's family members and the VA began to smoke cigarettes. The SP did not want to be around the smell and went to sit in the car. The SP stated that the VA was inside for ten to twelve minutes before coming outside but also stated that they smoked the same cigarettes outside that they lit while inside. The VA and his/her apparent family members were talking outside "for a long period of time," until the SP "pound[ed] the horn" and said that they had to return to the facility. The SP was concerned about the VA getting his/her medications. The VA returned to the car with a bag in his/her hands and possibly shoes. The SP denied knowledge of the VA getting any "drugs."

- On the drive back to the facility, the VA was acting "normal" and was talking to the SP. The VA sometimes "talked about [him/herself]" and the SP did not want to be distracted by the VA so s/he did not talk much. The VA never told the SP that the people s/he visited were not family members and referred to them as his/her parents. Several weeks after the incident, the SP re-read the text chain from the VA to his/her apparent family members, and the VA called the person by name, rather than by a parental name assignment such as "Mom" or "Dad."

- At around 5 p.m., P4 called the SP while they were driving back to the facility to ask about the missed medications. The SP told P4 that s/he made a mistake by not bringing the medications along.

- The T-Log dated May 31, 2025, and entered by the SP stated that the VA took several medications during a stop for gas and restroom break on the way back. It also stated, "[The VA] visited with [his/her] parents today at Duluth were [s/he] spent two hours with [his/her] parents discussing everything went well, we started on the road at 5:30 p.m. and arrived at 7:15 p.m., immediately we got in [s/he] received [his/her] bedtime medication at 7:55 p.m."

Facility documentation showed that on May 29, 2025, the VA requested an activity for May 31, 2025, to meet a family member at McDonald's in Hinckley. According to the *Activities Request* form, the purpose of the visit was so that the VA could get money back from a family member.

Another staff person noted in a T-log dated June 1, 2025, that the VA had not slept the previous night, was "very manic" and was "suspected to be on illegal substances, suspected to have received from housemate or family while visiting Duluth yesterday, suspected from extreme mania, uncontrolled and disorganized speech with a tone of topics getting more negative as the day went on."

T-Logs dated June 2, 2025, documented that the VA "rambled" for about 30 minutes and was "noticeably sweating." The VA went to his/her bedroom and was there for the remainder of the evening, but "did not seem to sleep for more than 90 min[utes], judging by sound from [his/her] room of talking to [him/herself]." Another T-Log for that day written by P3 stated that when P3 went to the VA's door, s/he could hear the sound of a "butane torch" clicking and lighting that the VA used for lighting cigarettes. When P3 knocked on the VA's door to give the VA medications, the VA did not come to the door. P3 notified an administrative staff person who told P3 to continue to remind the VA that there was no smoking at the facility and to document all occurrences.

A GER that was written on June 2, 2025, by P3, stated that the SP called P3 on speakerphone with the VA there. P4 stated that s/he reiterated to the SP that the VA was only approved for Hinckley outing and that the SP "understood."

Another GER was written on June 9, 2025, stated that it was "assumed" that the VA "obtained methamphetamine and a pipe" when up in Duluth and that s/he had been smoking it in his/her bedroom. The VA went "without sleep and food" from May 31, 2025, through June 2, 2025.

All staff persons interviewed were trained on the VA's plans and the Reporting of Vulnerable Adults Act.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245D.07, subdivision 1a stated 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 the support plan addendum, and in compliance with the requirements of this chapter.

Conclusion:

Information from P1, P2, P3, P4, and the SP showed that on May 31, 2025, the SP took the VA to Duluth to visit family members after initially having an outing scheduled for Hinckley to see a family member. According to P3 and the SP, they spoke on speaker phone in front of the VA. The VA told the SP that his/her family was in Duluth and that they needed to go there instead. P3 stated that the VA was only approved to go to Hinckley and the SP stated that P3 approved the change in plans and took the VA to Duluth.

The SP stated that s/he thought that the VA was visiting his/her parents at the Duluth residence because that was what the VA told P3. When they arrived, according to the SP, there was a gap in time, possibly up to one to two hours that they waited for the family to return home. The VA and the SP sat in the car. When they finally arrived home, the VA and the SP went up to the front door, but due to everyone smoking cigarettes, the SP went back to the vehicle to observe from the vehicle. The SP said the VA was inside for "ten to twelve minutes" but also said that the VA was smoking the same cigarette when s/he came back outside.

The VA stated that they were originally going to meet a family member in Hinckley and thought that s/he could be "unsupervised." According to the SP, the VA exited the home with a bag and possibly shoes. According to the SP and the VA, after visiting, they drove back to the facility and the SP stated that the VA was "normal," and the VA denied that s/he had been using drugs or that s/he brought them back from Duluth.

During the next few days, facility documentation and observations by staff persons, including P1, P3, and P4, stated that the VA did not sleep, eat, or drink, was acting "manic" and continued "behaviors" toward staff persons. On June 2, 2025, P3 found a "meth pipe" with "pooled" substance in it partway under the VA's pillow.

The VA denied being "high off meth" because s/he would have been "fucked up" in the vehicle and denied bringing "meth" back from Duluth and stated that s/he "wouldn't even know" if a staff person found a "pipe" in his/her belongings.

Although the SP left the VA unsupervised up to ten to twelve minutes during an outing to Duluth which was a violation of Minnesota Statutes, section 245D.07, subdivision 1a and two days later the VA had a methamphetamine pipe in his/her bedroom and had behavior similar to when s/he used methamphetamines in the past, given that the VA stated s/he did not obtain methamphetamine while on the Duluth outing, that the pipe was found two days after the outing so could not be determined where the VA obtained it, that the VA told the SP they were visiting the VA's family, and that the SP did not go into the house because of cigarette smoke but remained nearby in the car, 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's *Internal Review* showed that policies and procedures were adequate but not followed. There was not a need for additional training because the SP no longer worked at the facility. The VA's annual plan was updated to reflect drug exposure risks.

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

The facility was not issued a Correction Order for the violation outlined in this report because they took immediate corrective action. No further action was taken.