

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: 202508942

Date Issued: December 23, 2025

Name and Address of Facility Investigated:

Disposition: Inconclusive

Divine House Inc
832 Willow Springs Rd
Detroit Lakes MN 56501

Divine House Inc
328 5th St SW
Willmar MN 56201

License Number and Program Type:

1069238-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069140-HCBS (Home and Community-Based Services)

Investigator(s):

Elisa Montgomery
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
Elisa.Montgomery@state.mn.us
651-431-6474

Suspected Maltreatment Reported:

It was reported that a staff person (SP) called a vulnerable adult (VA) a "little bitch" and would frequently swear at the VA, making the VA uncomfortable.

Date of Incident(s): Unknown, Multiple Dates

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), clause (2):

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: 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.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on October 10, 2025; from documentation at the facility; and through eight interviews conducted with supervisory facility staff persons (P1-P3), facility staff persons (P4, P5), the VA's guardian (G), the VA, and the SP.

The VA was diagnosed with Marfan syndrome, schizoaffective disorder, and mild/moderate intellectual disability. The VA enjoyed fishing, bowling, being outdoors, and working on puzzles or sorting playing cards.

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

The VA was susceptible to emotional abuse and the VA's diagnoses affected his/her cognitive functioning. The VA "most likely" would not be able to identify emotional abuse or understand when emotional abuse was occurring. The VA "exaggerated" situations and staff would listen to the VA and "verify facts" that the VA shared with staff. Staff could communicate to the VA what constituted emotional abuse.

The VA provided the following information:

- When the SP first started working with the VA, s/he was "nice." The SP "pulled a fast one" on the VA and was "mean."
- At times, the VA did not feel like s/he was able to tell others how s/he was feeling because the SP would find out and get "mad" at him/her. The VA felt like "rocks were piling" on his/her back because s/he could not tell anyone.
- The VA was not able to recall dates or times but recalled that the SP would say the "f-word" at him/her and that the SP had called the VA a "bad name."
- On an unknown date, the SP picked up the VA's plastic water bottle and dropped it on the ground close to the VA. The water bottle cracked, making the VA upset.
- On another unknown date, the SP and the VA were at a main office discussing the incident when the SP called the VA a "bad name.". The VA felt "embarrassed" and "uncomfortable." After the meeting, the SP told the VA to stop talking to P1.

P1 provided the following information:

- On August 22, 2025, P1 was at the facility with the SP and the VA. P1 was giving the VA his/her routine diabetic foot care. The SP was sitting at the table near the VA and P1. The SP stated to the VA, "Why don't

you tell [P1] why you're being such a whiny little bitch?" P1 witnessed the SP say this two times before telling the SP to stop.

- P1 asked the VA if s/he was okay, and the VA shook his/her head, "No". The SP explained to P1 that the VA was "being a little bitch" because s/he did not want to shower. The SP believed that the VA was "nasty" for going to bed after being sweaty and covered in bug spray from the evening before. The VA explained that s/he was tired at the time and did not want to shower.
- The SP got up from the table and stood by the window and called the VA a "whiny little bitch" and "rudely" explained to the VA that because s/he had "mental issues" the SP needed to care for him/her. The VA put his/her head down and the SP asked the VA, "Are you going to take a fucking shower or not?". The VA did not respond and P1 quietly asked the VA if s/he could shower when P1 was done with the VA's diabetic foot care and the VA said, "Yes."
- When P1 was done, the VA got clothes to take a shower and P1 went to the office to finish documentation. The VA came into the office to talk to P1, but the SP yelled, "Leave [P1] alone." The VA left the office and took a shower. P1 did not have information regarding any other similar incidents involving the SP.
- On August 27, 2025, the VA was at the office where P1 worked. The VA attempted to talk to P1 in private about his/her concerns, but the SP had interrupted the conversation, and the VA no longer felt comfortable talking to P1.

P2 provided the following information:

P2 had went to the facility on September 21, 2025, for a "house check" and talked with the VA. The VA expressed to P2 that s/he "does everything wrong" and "gets everyone in trouble." The VA discussed with P2 that s/he was "scared" to talk to anyone about how s/he was being treated by the SP.

P3 provided the following information:

- The VA had a history of discussing his/her concerns and at times would provide information that was not accurate or would be how the VA "felt" staff were acting towards him/her. The VA had a history of contacting 9-1-1 for non-emergent situations. When this occurred, staff would talk with the VA about "consequences" of making frequent calls for non-emergent situations.
- After the SP was suspended from working at the facility on September 26, 2025, P3 went to the facility to discuss the VA providing inaccurate information and how it leads to staff not being able to work with the VA at the facility.
- P3 did not have further information regarding the incident that the SP called the VA names and did not believe that the SP would have reason to do so.

P4 provided the following information:

- P4 had not witnessed the SP being “mean” to the VA. The SP would “push buttons” to motivate the VA to shower or participate in an activity but when the VA would get upset, the SP would “back off.”
- The VA would tell P4 that the SP had thrown objects at the VA but when P4 would ask further questions, the VA would tell P4 that the object was dropped near him/her.
- The VA discussed with P4 briefly that the SP had thrown the VA’s water bottle at him/her. P4 asked if the water bottle was thrown and the VA said that it was dropped, broken, and water spilled everywhere. The VA no longer wanted to discuss the incident.
- The SP would not swear at the VA but swear words would be used in conversation not directed at the VA. P4 did not have concerns regarding the SP working with the VA.

P5 provided the following information:

P5 did not have information related to the incident and the VA had not discussed concerns with P5. P5 did not have concerns with the SP working with the VA and s/he stated that the SP always worked well with the VA.

The SP provided the following information:

- At times that when working with the VA that the SP would swear but it was never directed toward the VA or when listening to music with the VA, the lyrics would contain swear words. The SP denied that s/he had called the VA a “little bitch” or any other derogatory term.
- Regarding the water bottle, the water bottle was set on a table or something similar. The SP was encouraging the VA to take a shower and kept pushing the water bottle closer to the edge of the table. The water bottle fell onto the floor and cracked, leaking water. The SP cleaned up the water and apologized to the VA.

The G provided the following information:

The G did not have concerns with the facility. The G expressed that the VA had a history of “misperceiving” and “misreading” people and situations.

The facility’s *Internal Review* provided the following information:

- The SP’s comments and communication styles were “unprofessional” and were “inconsistent” with trauma-informed care.
- Staff comments and communication styles could have contributed to “distress” that the VA had expressed and that some interactions between the SP did not meet the expectations for “respectful” and “supportive care.”
- The SP was being transitioned to a different facility to give the SP and VA “temporary separation” if the VA wished to work with the SP in the future.

Relevant Minnesota Statutes and/or Rules:

Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (6) stated that a person's protection related rights included the right to be treated with courtesy and respect and receive respectful treatment of the person's property.

Conclusion:

Information showed that on August 22, 2025, P1 was at the facility with the SP and the VA. P1 was giving the VA his/her routine diabetic foot care. The SP was sitting at the table near the VA and P1. The SP stated to the VA "Why don't you tell [P1] why you're being such a whiny little bitch?" P1 witnessed the SP say this two times before telling the SP to stop. P1 asked the VA if s/he was okay, and the VA shook his/her head. The SP explained to P1 that the VA was "being a little bitch" because s/he did not want to shower.

At times, the VA did not feel like s/he was able to tell others how s/he was feeling because the SP would find out and get "mad" at him/her. The VA was upset that on one occasion, the SP had picked up the VA's plastic water bottle and dropped it on the ground close to the VA and the water bottle cracked. The VA was not able to recall dates or times that these incidents had occurred.

On September 21, 2025, P2 went to the facility for a "house check" and talked with the VA. The VA expressed to P2 that s/he "does everything wrong" and "gets everyone in trouble." The VA discussed with P2 that s/he was "scared" to talk to anyone about how s/he was being treated by the SP.

P4 had not witnessed the SP being "mean" to the VA. At times, the VA would tell P4 that the SP had thrown objects at the VA but when P4 would ask further questions, the VA would tell P4 that the object was dropped near him/her. The VA discussed with P4 briefly that the SP had thrown the VA's water bottle at him/her. P4 asked if the water bottle was thrown and the VA said that it was dropped, broken, and water spilled everywhere. The SP would not swear at the VA but swear words would be used in conversation not directed at the VA.

P3 and P5 did not have concerns with the SP and did not have relevant information related to the incident that the SP had called the VA a "little bitch" or if the SP had purposefully thrown or broke the VA's water bottle. P3 and P5 did not have concerns regarding the SP working with the VA.

The SP denied that s/he had called the VA "little bitch" or any other derogatory term. The SP was encouraging the VA to take a shower and kept pushing the water bottle closer to the edge of the table. The water bottle fell onto the floor and cracked, leaking water. The SP cleaned up the water and apologized to the VA.

Although it was likely that the SP called the VA a "little bitch" more than once on August 22, 2025, which was a violation of Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clause (6), and was behavior inconsistent with the standards of a professional caregiver working at a facility licensed by the Department of Human Services, and the SP accidentally broke the VA's water bottle, given that there was no information that there were other occurrence of the SP calling the VA "a little bitch," there was not a preponderance of the evidence whether the SP's conduct was repeated and rose to the level of emotional abuse.

It was not determined whether 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: 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).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but were not followed. The SP received retraining regarding Employee Conduct and Discipline Policy, Prohibited Employee Conduct, respect individual rights, autonomy, and freed from coercion or unnecessary restriction, and Maltreatment of Vulnerable Adult Reporting Policy and Procedure.

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.