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: 202507492

Date Issued: January 6, 2026

Name and Address of Facility Investigated:

Dungarvin Minnesota Croixwood
653 Hidden Valley Court
Stillwater, MN 55082

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

Disposition: Substantiated as to neglect of a vulnerable adult by a staff person.

License Number and Program Type:

1070900-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070806-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) allowed a vulnerable adult (VA) to access an area where medications were kept where the VA took a housemate's medications and overdosed, which led to hospitalization. It was also reported that the VA went for "over two weeks" without medication because the medications were out.

Date of Incident(s): July 2025 and August 15, 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.

<u>Summary of Findings</u>:

Pertinent information was obtained during a site visit conducted on September 2, 2025; from documentation at the facility, law enforcement records, medical records; and through nine interviews conducted with the VA, facility staff persons (SP, P1, P2, P3, and P4), facility supervisory staff persons (P5 and P6), and the VA's guardian (G).

The VA's diagnoses included autism, Tourette's syndrome, anxiety, and post-traumatic stress disorder. The VA liked to play basketball, soccer, and video games. The VA had one hour of unsupervised time at the facility.

The facility was a one-story single-family residence in a residential neighborhood. The main level had two living rooms, an office, a kitchen, a dining room, three bedrooms, two bathrooms, and a garage. The basement was unfinished.

The facility's *Policy and Procedure on Medication Labeling, Storage, Destruction, and Transfer* stated, "All medications, unless noted below, will be stored in a designated area away from direct sunlight and/or frequent (intense, high levels) humidity. All medications will be stored according to the manufacturer's directions. This area may or may not be locked depending upon the safety needs of the individuals being served." The facility's *Policy and Procedure on Medication Administration* stated, "The staff person will be responsible for the security of the medication cabinet key, medication cabinet/storage area, and the medications. When not in use, the medication cabinet/storage area will be kept locked at all times. Unlocked medication cabinet/storage areas will be maintained in a safe, controlled manner to prevent access or disturbance by individuals."

The G provided the following information:

- On August 15, 2025, at approximately 9:30 p.m., the VA called the G from the SP's phone and stated s/he called 9-1-1 because s/he overdosed. The G also spoke to the emergency medical technician (EMT). The G did not believe the VA at first and told the VA maybe s/he was just anxious or having a panic attack. The VA said the G was "probably right." The VA did not say s/he had taken someone else's medications. The EMT checked the VA's vitals, which were normal and "assumed" it was a panic attack. The SP said s/he only gave the VA his/her four medications.

- On August 16, 2025, the G got a call from P1 and was informed that the VA was taken to the hospital. The G was told the VA was not him/herself, had urinated on him/herself, and medication was missing from the office. P1 believed the VA took a housemate's medication, olanzapine, because it was all gone. It was believed the VA took approximately 30 pills.

- The VA told the G s/he was feeling "depressed" that night and was not sure why s/he took the medication. The VA told the G the SP was sleeping and the office was open and the medication "wasn't locked up." In a later conversation, the VA told the G s/he had asked the SP for a snack and the SP told the VA to get it him/herself. The VA went into the office and took the pills. The VA had "stuck" with that story

since.

- The VA had "lied" in the past about things but was able to provide reliable information.

The VA provided the following information:

- On an unknown date in August 2025, the VA asked the SP for a snack. The snacks were kept in the office. The SP told the VA to go in the office and get a snack. The SP was on his/her phone and remained on a couch in one of the two living rooms, which was farthest from the office. The VA was not allowed in the office without staff.

- The office door was open and unlocked. The VA went into the office with the intention of getting a snack. The VA stated the medication cabinet was closed but unlocked. The VA opened the medication cabinet and took a bottle of unknown medication that did not belong to him/her and went to his/her bedroom. Only the VA and the SP were at the facility at the time.

- The VA estimated s/he took 23 pills of the medication at 6 p.m. The VA "didn't really like life" when s/he took the pills. The VA threw the bottle away in the garage garbage. The VA thought someone took the garbage out the next morning.

- The VA felt "weird" and called an ambulance around 6:15 p.m. The VA told the ambulance crew s/he had taken some medication and estimated s/he took 23-34 pills. The VA was checked out by the ambulance crew and was told his/her vitals "look good" and there was "nothing wrong." The ambulance then left.

- The VA informed the ambulance crew that s/he had taken medication and told the SP that s/he overdosed. The SP did not ask the VA any questions about what medication the VA had taken.

- The VA felt "tired and drowsy" and went to sleep around 8 p.m. The VA woke up in the hospital and did not remember anything else.

- When the VA first moved to the facility in June of 2025, s/he did not have his/her prescription medications for 11 days. The G texted P6 and P6 did not answer the G. The VA asked the G to purchase over the counter medications melatonin and vitamin D to help the VA sleep.

- During the time when the VA did not have the prescription medications, the VA felt "jittery" and "depressed."

P1 provided the following information:

- On August 15, 2025, P1 worked 7 a.m. to 11 p.m. P1 worked with the VA from 7 a.m. to 3 p.m. and then with the housemate from 3 to 11 p.m. The SP started working with the VA at 3 p.m. The VA was "fine" while P1 worked with him/her. At 5:29 p.m., P1 took the housemate to a friend's house. The SP and the VA were not at the facility when P1 left. P1 locked the office door prior to leaving and left the keys locked in the office. P1 did not return to the facility until 10:34 p.m.
- When P1 was gone from the facility, the SP called P1 three times. The first call was around 6 p.m. and the

SP asked P1 for the code for the lockbox outside the front door to get the key for the office. The SP called P1 a second time and asked where P1 was at. The SP called a third time and asked when P1 would be back at the facility. P1 asked if anything was wrong and the SP said, "No, everything is fine." When P1 returned to the facility, the VA was asleep and the SP said everything was "fine." The SP did not tell P1 that the VA had called 9-1-1 or stated that s/he had overdosed.

- On August 16, 2025, P2 called P1 around 6:45 a.m. and said, "Something was off" with the VA. P1 arrived at the facility and P2 was getting medication ready for the housemate. P2 could not find the housemate's bottle of medication. P1 packed a dose of the housemates' medication on August 15, 2025, before they left and put the bottle back in the medication cabinet.

- P1 believed the VA took the missing medication during the 3-11 p.m. shift on August 15, 2025. The SP had called P1 several times during that shift when P1 was offsite and it was noted in shift documentation that the VA called 9-1-1 to report s/he overdosed. P1 and P2 went into the VA's bedroom and observed the VA sitting on the floor in urine. P1 called the VA's name and the VA stared at his/her fingers. The VA was "completely out of it." P1 called P5 and the G. The VA was transported to the hospital by ambulance. No other medications were missing.

- Medications were kept in the medication cabinet in the office and were locked up at all times. The office was supposed to be locked at all times.

- P1 stated the VA had food at the facility and that the deep freezer downstairs and the fridge were full of food. The VA picked out two multipack boxes of snacks per month. The snacks were kept in the office. The VA "binge" ate and had eaten all the snacks before.

- P6 was in charge of medication refills when the VA moved in. P1, P2, and another staff person told P6 on "multiple occasions" that the VA and the housemate did not have any medications. P1 believed the VA was out of medication for "a week or two." P5 was notified, however, P1 did not know the outcome.

- P1 stated the VA provided reliable information.

P2 provided the following information:

- On August 16, 2025, at 6:45 a.m., P2 arrived for work at the facility. P2 sat at the dining room table and saw the VA "crawling" out of his/her bedroom. The VA pulled him/herself up to the table and into a chair. P2 asked the VA what was wrong. The VA "couldn't get words out" and his/her eyes were "closed up." P2 asked P3 what was wrong with the VA and P3 stated, "[The VA] was tired because [s/he] was up all night." P2 asked the VA if s/he wanted to go back to bed and helped the VA back to his/her bedroom. P3 left the facility and P1 arrived and called 9-1-1.

- Emergency personnel arrived and P2 was getting medication ready for the housemate. P2 was unable to locate the housemate's bottle of olanzapine. P2 asked P1 where the olanzapine was at and P1 said it was in the cabinet. P2 remembered reading the VA's notes and saw that the VA called the ambulance around 9 p.m. on August 15, 2025, and the VA told paramedics s/he overdosed.
- The emergency personnel asked the VA if s/he had taken anything and the VA answered, "Yes." P2

estimated the bottle should have had approximately 30 pills in it.

- After the VA moved into the facility mid-June 2025, the VA was out of medications. P2 estimated the VA went without medications for two weeks or more. "Everyone" told P6 that the VA was out of medication. If staff persons signed the medication administration record (MAR) and said they gave the VA medication in June 2025, they were "lying" because the prescribed medication like Haldol and clonidine were not at the facility. P2 did not work directly with the VA but was a "busy body" and tried to make sure everything was right. P2 did administer medication to the housemate during that time and would have seen if the VA's medication was in the medication cabinet. The G bought melatonin and a multivitamin for the VA.

P3 provided the following information:

- P3 worked the overnight shift on August 15, 2025, which was 11 p.m. to 7 a.m. When P3 arrived at the facility, the VA was already asleep. P3 did not administer any medication during the shift. The VA woke up between 3-4 a.m. and used the kitchen, laid down for a little bit in the living room and then went back to bed. P3 stated the VA was checked on two times overnight.

- The VA was "kind of okay until the morning." Just prior to 7 a.m., the VA came out of his/her room and was "showing some symptoms." P3 asked the VA what was wrong and the VA said s/he was "probably too sleepy." P2 took the VA to his/her room and P3 took out the garbage and left.

- The VA went to the hospital and P3 picked the VA up later that day. The VA told P3 that s/he took the medication around 9 p.m., while the SP was sitting in the living room.

- P3 "barely" worked at the facility. The office door was locked and the cabinet was locked. P3 had never seen the door unlocked.

P4 provided the following information:

- On an unknown date, P4 arrived at the facility to work the overnight shift. The VA came out of his/her bedroom one time around 11 p.m. and got food from the refrigerator and went back to sleep. The VA looked like s/he "wasn't feeling well." P4 thought the VA was just tired. P4 did not see the VA any other time during the shift. P4 left the next morning around 7 a.m. when P2 arrived.

- P4 was in the office during the shift and did not administer any medication during the shift.

- The office door was kept locked unless staff persons were in the office. The medication cabinet was always locked.

- P4 never administered medication during his/her shifts and did not have knowledge if the VA was ever out of medication.

- The VA "changes" stories "a lot" and most of the stories were "not trustworthy."

P5 provided the following information:

- On August 16, 2025, P1 notified P5 that the VA was dizzy, delusional, and had urinated him/herself. The VA told P1 s/he had taken several pills so P1 called 9-1-1.

- P5 believed the VA accessed medication, took an unknown amount of olanzapine, and overdosed on August 15, 2025.

- The VA had called 9-1-1 around 9 p.m. on August 15, 2025, and stated s/he had overdosed. The VA was checked out by the ambulance crew and it seemed like the VA was suffering from anxiety or a panic attack. The SP was the VA's staff person at the time.

- Medications were kept in a locked medication cabinet in a locked office. Staff persons had keys to the office and medication cabinet. The SP told P5 the office was never left unlocked or unattended during his/her shift on August 15, 2025.

- P1 told P5 the office was closed and locked when P1 left with the housemate.

P6 provided the following information:

- P6 did not work when the incident happened and returned to work on August 18, 2025.

- After the VA moved into the facility, s/he ran out of medication for "three to four days." P6 stated the house manager at the time stopped showing up for work and staff persons did not notify P6 until the VA ran out on July 15, 2025, which delayed getting the medications refilled. P6 scheduled a medical appointment for the VA which was required to get the VA refills.

- The medication administration record (MAR) was not put in place the first week the VA was at the facility and P6 believed the VA had medications until the VA ran out on July 15, 2025.

The SP provided the following information:

- On an unknown day in August 2025, the SP took the VA to the park. When the SP and the VA returned to the facility, P1 and the housemate were gone.

- The SP stated when they arrived back at the facility from the park, the office door was open and the medication cabinet was closed and locked. The keys were on the desk in the office.

- The office door was kept open unless no one was at the facility. The SP did not know the "rule" about clients going into the office and never saw staff persons say clients could not go in the office.

- The facility had two living rooms on the main level. The SP was in the living room closest to the office. The VA asked for a cold drink from the office. The SP told the VA, "Go ahead, grab it." The VA went into the office alone and came back out.

- Around 8 p.m., the SP administered "four tablets" of bedtime medication to the VA. Later, the VA told the

SP it felt like s/he had "overdosed." The SP was unaware that the VA had called 9-1-1. The ambulance arrived at the facility and the SP called the VA's G. The ambulance crew checked the VA's vitals and stated everything was okay. The G stated the VA sometimes overreacted.

- After the VA told the SP that s/he felt like s/he overdosed, the SP did not check to see if any medication was missing.

- The VA went to bed and the SP left after his/her shift ended at 11 p.m. The SP later learned that the VA had been taken to the hospital and that the housemate's medication was missing.

- The SP originally stated the office door was open when they went to the park and P1 was still at the facility. The SP later stated P1 left the facility first and the SP shut the office door and locked it before leaving for the park. The SP did not remember where the key was when s/he returned to the facility. The SP unlocked the office door and left the door open. The SP did not think the office door needed to be locked when staff persons were at the facility. The medication cabinet was locked. The keys for the medication cabinet were on the desk in the office when the VA went to get a drink.

Facility training records showed the SP was trained on the VA's plans and all staff persons interviewed were trained on the Reporting of Maltreatment of Vulnerable Adults Act.

Relevant Minnesota Rules and or Statutes:

Minnesota Statutes, section 245D.05, subdivision 2, paragraph (c) stated that the license holder must ensure the documentation of medication administration.

Minnesota Statutes, section 245D.05, subdivision 1 stated that the license holder was responsible for meeting health service needs consistent with the person's health needs.

Conclusion:

A. Maltreatment:

Regarding the VA obtaining and consuming olanzapine:

Information showed that on August 15, 2025, the SP took the VA to the park. P1 and the housemate left the facility at 5:29 p.m., while the SP and the VA were gone. Both the SP and P1 claimed to have been the one that shut and locked the office door. The SP and the VA arrived back at the facility and the SP unlocked the office door and left it open. The VA asked the SP for a snack, which was kept in the office. The SP told the VA to go grab a snack and did not escort the VA into the office. The VA stated the medication cabinet was closed but not locked. The VA opened the cabinet and took a bottle of the housemate's medication olanzapine and went to his/her room. The VA consumed approximately 30 pills from the bottle and threw the bottle in the garbage in the garage. The SP administered the VA's night medications. The VA called 9-1-1 and told the SP s/he overdosed. The SP did not check to see if any medications were missing. An ambulance arrived and assessed the VA. The VA told the ambulance crew that s/he had taken a large number of pills. The VA's vitals were normal and the G was contacted. The G and the ambulance crew felt the VA had anxiety issues and did not transport the VA away from the facility.

P1 and the housemate returned to the facility at 10:34 p.m. The SP did not tell P1 the VA called an ambulance or stated s/he overdosed. The overnight staff, P3 and P4, had little interaction with the VA and noted the VA appeared "sleepy."

P2 arrived at the facility at approximately 6:45 a.m. on August 16, 2025. The VA "crawled" out of his/her room and could not speak. P2 asked P3 what was wrong with the VA and P3 stated the VA was sleepy. P1 arrived at the facility a short time later and observed the VA sitting in his/her room in urine. P2 discovered the housemate's olanzapine was missing. P2 read in the VA shift notes that the VA had claimed to have overdosed and had called an ambulance the previous evening. P1 called 9-1-1 and requested emergency personnel for an overdose. The VA was transported to the hospital for evaluation and observation.

The facility's *Policy and Procedure on Medication Administration* stated, "The staff person will be responsible for the security of the medication cabinet key, medication cabinet/storage area, and the medications. When not in use, the medication cabinet/storage area will be kept locked at all times. Unlocked medication cabinet/storage areas will be maintained in a safe, controlled manner to prevent access or disturbance by individuals." Staff persons interviewed stated the office and medication cabinet were kept locked. The SP stated the office door was left unlocked and open when staff were present at the facility and the medicine cabinet was kept locked with the keys on the desk in the office.

Although the SP denied allowing the VA to access medications, given that the SP did not tell a supervisor or other staff persons that the VA stated that s/he overdosed and an ambulance responded, that the SP did not check to see if any medications were missing when the VA told the SP s/he overdosed, that the SP did not keep the office locked or the medication cabinet secured and inaccessible to the VA and allowed the VA to go into the office unsupervised to get a snack, which resulted in the VA accessing medication and overdosing, there was a preponderance of the evidence that the SP failed to provide the VA with reasonable and necessary care and services to maintain the VA's physical 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 was 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).

Regarding the VA running out of medications:

Information also showed that after the VA moved into the facility in June of 2025, the VA ran out of medication. There was inconsistent information provided regarding how long the VA went without medication. P1 and P2 stated P6 was told several times that the VA was out of medications. P1 and P2 estimated it was one week to more than two weeks that the VA did not have medication. P6 stated when the VA moved into the facility, the medication administration record (MAR) was not yet in place so medication that was administered was not documented. P6 stated arrangements were supposed to have been made prior to the VA moving to the facility to have the VA set up with a psychiatrist for medications and that did not happen. P6 stated s/he was not told the VA was out of medication until the day the medications ran out on July 15, 2025. P6 made the VA an appointment for July 18, 2025, and medications were refilled. P6 stated the VA was without medications from July 15 to 18, 2025. Other days missing initials on the MAR were possibly due to staff forgetting to sign the record.

Although the VA was out of medications for an unknown number of days because an appointment was not made which was in violation of Minnesota Statutes, section 245D.05, subdivision 1, and medication administration was not documented on the MAR as required which was a violation of Minnesota Statutes, section 245D.05, subdivision 2, paragraph (c), given that there was conflicting information regarding how many days the VA did not have medications, that once the VA ran out of medications and that P6 called to schedule an appointment so the VA could get refills, 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 was 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;
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> (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.

The SP was responsible for the care and supervision of the VA at the time of the incident. The SP was 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 substantiated neglect for which the SP was responsible did not meet the statutory criteria to be determined as recurring because it was a single incident or serious because although the VA went to the hospital, the VA did not require care of a physician.

Action Taken by Facility:

The facility’s *Internal Review* stated the reported event was not similar to past events, policies and procedures were adequate and were not followed, there was a need for additional staff training, and there was a need for corrective action by the facility to protect the health and safety of the VA. The SP failed to follow the VA’s plan by allowing the VA to enter the staff office unsupervised, which resulted in a lack of supervision. The SP also violated facility policy by leaving the medication cabinet and staff office unlocked when not in use. All staff persons failed to follow facility policy and failed to re-order medications when there was less than a seven-day supply.
The SP no longer worked at the facility. All staff persons were retrained on the medication refill policy.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in

this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

On January 6, 2026, the facility was issued a Correction Order for the violations outlined in this report.