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: 202508309

Date Issued: January 21, 2026

Name and Address of Facility Investigated:

Disposition: Inconclusive

Cardinal Of Minnesota LTD
1330 48th Ave
Goodview, MN 55987

Cardinal of Minnesota, Ltd.
3008 Wellner Dr. NE
Rochester, MN 55906

License Number and Program Type:

1068932-H_CRS (Home and Community-Based Services-Community Residential Setting)
1068906-HCBS (Home and Community-Based Services)

Investigator(s):

Jamie Randall
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
jamie.randall@state.mn.us
651-431-4121

Suspected Maltreatment Reported:

It was reported that a facility staff person (SP) taunted and upset a vulnerable adult (VA) which resulted in the VA hitting, kicking, and headbutting hard surfaces. It was also reported that bruises were noticed on the VA's shoulder following a shift that the SP worked with the VA.

Date of Incident(s): September 6, 2025 and prior to September 7, 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 2, paragraph (b), clauses (1) and

(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:

- 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.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on October 16, 2025; from documentation at the facility and law enforcement records; and through eight interviews conducted with three supervisory staff persons (P1-P3), four facility staff persons (P4-P7), and the VA's guardian (G). This investigator met the VA, but the VA was not interviewed due to his/her disability. Attempts were made via telephone, text message, and certified and uncertified mail to contact the SP to request an interview, but the SP did not respond. The SP declined to speak with law enforcement. The SP provided information for the facility's internal review and that information was included below.

The VA enjoyed being outside and spending time with family. The VA's diagnoses included moderate intellectual disabilities and seizure disorder. The VA used "vocal cues," and staff persons were trained on what "cues to look for to avoid incident." Staff persons were trained on when to "redirect and avoid interaction." The VA had a history of "head banging, kicking objects, kicking people, biting and purposely hitting others." Staff persons were trained to tell the VA, "Head up, feet down, hands down," when the VA presented those behaviors. The VA was working on adaptive programming including socialization skills, completing daily living skills, and an "education" program.

The facility was two stories with a main floor and basement. The VA's bedroom was on the main floor. The basement had a staff office where medications were kept.

P5 provided the following information to this investigator, law enforcement, and for the facility's internal review:

- On September 6, 2025, P5 arrived for his/her shift at 3 p.m. P6 and the SP were working when P5 arrived. The VA was in a living room on the main level of the facility, had his/her hand covering his/her face in a "face palm," and did not want to "do anything." After ten minutes, P5 went back to the VA and the VA interacted with him/her. P5 left the VA and assisted one of the VA's housemates in his/her room that was at the end of a hallway on the main level of the facility.

- The SP left a bathroom that was next to the housemate's room. The housemate's room door was open and P5 heard the SP "interacting" with the VA and then heard the VA "headbang" a wall. P5 went out of the housemate's room and saw that the VA was in a "face palm." The SP "got into" the VA's face, waved and said, "Goodbye [the VA]." The SP walked backwards down the hallway toward the front door. The VA followed "swatting" at the SP while the SP repeated "bye" multiple times. The SP asked the VA if s/he

wanted to "slam the door" and the VA hit the front door. The SP went outside and waved at the VA through the front door window. The VA banged his/her head multiple times on the front door. P5 made a "shoo" gesture with his/her hand through the window and the SP left the facility.

- Progress notes written by P5 for September 6, 2025, included that the VA was sitting at the dining room table and fell "forward flat on [his/her] face." The VA was assisted by P5 to a seated position and then to a standing position. The VA resumed normal activities and was "without any signs of pain or injury" following the fall.

- On September 7, 2025, P5 arrived for a shift at 3 p.m. P6 left when P5 arrived, and the SP left at 4 p.m. P5 and the SP did not discuss the events from the day prior. The VA had "quite a few" falls over the weekend and recalled a specific fall on September 7, 2025, when the VA fell "flat backward." No injuries were noticed on the VA. The VA would typically fall when s/he had seizures. An incident report filled out by P5 said that at 4:30 p.m., the VA "suddenly fell backwards into the kitchen counter" and sat on the floor in a seated position with "[his/her] eyes closed for 10 seconds while kicking [his/her] feet slightly." P5 assisted the VA to his/her feet and the VA went to his/her room and watched tv.

- On an unknown day after September 7, 2025, bruises were noticed on the VA's shoulder by the G and P7. The bruises were a "finger or thumbprint" in size. The SP assisted the VA with a bath on September 7, 2025, and it was suspected that the SP used "force" that caused the bruises on the VA's shoulder. P5 did not provide further details for why the SP was suspected to have used force. P5 did not see any bruises on the VA on September 7, 2025.

P6 provided the following information to this investigator and for the facility's internal review:

- On an unknown date either the weekend of September 6 and 7, 2025, or a prior weekend, P6 and the SP were working a shift together. The VA became "upset," walked away from the SP and P6 and "ran" into a wall falling onto the floor. P6 and the SP went over to the VA and checked on the VA. The VA "seemed okay" but then stood up and scratched at the SP. The SP and P6 gave the VA "space." The SP grabbed a pillow and used the pillow as a "shield." P6 did not remember what happened next.

- On September 7, 2025, P6 arrived for a shift at 8 a.m., and worked with the SP. In Between 8 a.m. and 12 p.m., P6 was in the basement in the staff office preparing medications when s/he heard the SP take the VA into the bathroom to assist with a shower. P6 though that it was "strange" for the SP to assist with the VA's shower as the SP had not done that on shifts prior when working with P6. The VA was "particular" with who helped him/her with a shower and the SP was not one of the VA's "preferred" staff. P6 heard the VA "scream," which was not abnormal for the VA, and thought that the VA may have been vocalizing that s/he did not want to take a shower.

- After the SP assisted the VA with a shower, the SP told P6 that the VA bit him/her on the shoulder. The SP asked P6 if s/he should document the bite and asked P6 to text P3. P6 texted P3 and P3 responded that photos should be taken and sent to a facility nurse.

- P6 did not remember a situation where the SP was "taunting" and "upset" the VA while the SP was leaving. The SP might have thought his/her general interactions with the VA were "playful" but were

"rude" and could come across as "taunting."

P1 provided the following information to this investigator and for the facilities internal review completed by P1:

- On September 7, 2025, the SP, P5 and P6 were working at the facility. The VA was "off [his/her] game" and had a lot of screaming throughout the day. P5 told P1 that as the SP was leaving his/her shift around 5 p.m., the SP was repeatedly saying "goodbye" to the VA. The VA responded putting his/her face in his/her palm of his/hand and "headbanging." The SP asked the VA if s/he wanted to "slam the door" as the SP was at the front door. This caused the VA to "charge" toward the front door and hit the door with his/her fist and banged his/her head against the door. The SP stood outside the front door and waved at the VA. The VA continued to hit the front door until P5 made a "shoo" gesture through the front door window and the SP left.

- On September 8, 2025, the G called P1 to discuss bruises found on the VA. The G had concerns over the SP's interactions with the VA over the weekend which s/he heard about from P5 and wanted to discuss next steps. The G shared pictures of bruises on the VA. The VA had bruises on his/her shoulder, arm, and buttocks. The G was concerned with the bruises on the VA's shoulder as they looked like fingerprints. P1 though that the bruises looked like bruises the VA had in the past. The bruise on the back of the VA's shoulder looked "fresh" and was dark purple. The VA had a seizure disorder, was a fall risk, and bruised easily. P1 told the G that situation with the SP would be discussed with the management team at the facility.

- P5 and P6 did not tell P1 of any bruising and/or injuries with the VA. P5 did say that the VA fell during a seizure. The SP told P1 that s/he did not "antagonize" or "provoke" the VA in any way.

P2 provided the following information to this investigator and law enforcement:

- On September 8, 2025, P2 was notified that the VA had two seizures over the weekend that caused the VA to fall. P5 told P2 that on September 7, 2025, as the SP was leaving the facility through the front door, the SP antagonized and "mocked" the VA by "making faces" and "taunting" the VA. The VA responded by hitting his/her head on the front door window. The G talked with P2 on the same date and repeated the same concerns with the SP that s/he talked to P1 about. The G brought up bruises on the VA including one that was on the VA's shoulder area.

- The VA did not want to go into the shower on September 8, 2025. The VA let out a "high pitch squeal" and would not go into the shower. While the VA would "squeal" when happy, s/he would also "squeal" when s/he did not want to do something. The VA normally would take a shower, and the refusal was "odd behavior" for the VA. The VA continued to refuse a shower and did not do so until the G came to the facility to assist. The G though that "something" must have happened in the shower with the SP as s/he was the last staff person to assist the VA with a shower.

- The VA had a history of bruises to his/her head from hitting his/her head on different objects and "little bruises" on the body from where the VA would "bump" into furniture. The VA was a fall risk and most of the VA's falls were seizure related.

P7 provided the following information:

- On an unknown Monday in August or September 2025, P7 worked a morning shift. A staff person that worked the overnight told P7 that the VA had been up since 4:30 a.m. Between 8 and 9 a.m., P7 tried to assist the VA with getting into the bathroom for a shower but the VA refused by pushing P7. P7 "backed off" and waited to redirect. P7 tried again and was able to help the VA into the bathroom. P7 assisted the VA with personal cares and noticed the VA had a bruise on the back of his/her shoulder that looked like a "thumbprint" and on the front of the same shoulder were "three fingerprint" bruises (note: P7 did not say which shoulder). The VA also had bruises on both elbows with "fresh sores," bruises on both of the VA's ankles, and "two or three" bruise spots on the VA's thighs. One of the VA's ankles looked "swollen" but P7 could not tell "for sure." P7 turned on the water for a shower and the VA "screamed" and refused to take a shower. The VA did not refuse showers "often" and was not "extreme" when refusing on previous occasions. P7 called the G to have him/her come over to assist the VA with a shower. After the G and P7 assisted the VA with a shower, the VA went on a van ride with the G. The VA was "moody" for the rest of the day and kicked at P7 when s/he was assisting the VA with his/her nighttime routine.

- For the next "week and a half," the VA "struggled" with showers and would refuse to participate in regular activities.

- The VA struggled with shift changes between staff persons and may hit or bite his/herself, housemates, or staff persons. The VA may "charge" into things and hit his/her head on objects. The VA had a history of falls and fell "several" times during the weekend prior to including during "several" seizures.

- The VA "hated" the SP and would "scream" when the SP was in the same room as the VA. The VA would "punch" and "hit" in the direction of the SP. A "couple" of times, the SP took a stuffed animal, put it close to the VA's face and would say, "Do you want to hit this?" and "Do you want to hit your head on this?"

P4 provided the following information:

- On an unknown Tuesday, P4 worked a morning shift with the VA. The VA was "super out of it" and had bruises on the front of his/her shoulder and on both knees (note: P4 did not remember which shoulder had the bruises). The bruises on the VA's shoulder were a "thumbprint" bruise with a larger bruise the size of a "fist" surrounding the "thumbprint" bruise. The bruises on the VA's knees looked like "rug burn." The VA had a history of seizures and would normally be "out of it" the day after but the VA seemed "more out of it." The VA did not want to shower and appeared to be in pain from the shoulder bruise as s/he could "barely" lift his/her arm when putting clothes on.

- For the rest of the same week, the VA seemed "out of it" and was not like him/herself. The VA refused showers and was not eating as much as normal. When staff persons would approach the VA, the VA would "get up" and walk away. P4 felt "something had to have happened" for the VA to act different than normal. While the VA had a history of falls and had self-injurious behaviors which included biting him/herself and "headbutting" doors and walls, the VA "never" had that many bruises "at once."

- The VA did not like the SP and would "runaway" from him/her or try to "charge" at him/her.

The G provided the following information to this investigator and law enforcement:

- On the morning of September 6, 2025, the G assisted the VA with a shower and there were "no marks" on the VA. Over the weekend of September 6 and 7, 2025, the VA had four seizures and had fallen.

- On September 7, 2025, the G was notified by P5 that the SP "upset" the VA by "making faces" through a glass door.

- On September 8, 2025, the G was notified by P7 that the VA had a bruise on his/her left collarbone area, a bruise on the left elbow, and a bruise on his/her ankle. The VA became "upset" when P7 tried to assist the VA in the bathroom and did not want to be in the bathtub. The bruise on the VA's ankle looked like someone could have "stepped" close to or on the VA's foot. The VA would kick things, and it was not uncommon for the VA to have bruises on his/her feet, but the ankle was an abnormal place for the VA to have a bruise. The bruise on the VA's collarbone looked like a thumbprint and that someone may have grabbed the VA's shoulder (note: the law enforcement report said the G thought the bruises "maybe" looked like a thumbprint, but the G was unsure. The law enforcement report did not specify which bruises the G thought may have been a thumbprint). P7 took pictures of the bruises and sent them to the G (note: law enforcement received photos from the G and noted a "possible bruise and scratch" on the VA's "collar bone," a "bruise and scrape" on the VA's elbow, a "bruise" on the VA's "legs," and a "bruise/scrape" on the VA's ankle. After reviewing the photos, the officer was unable to determine when and how the VA sustained the marks). After sending the pictures to the G, P7 told the G that the SP and the VA "didn't get along."

- A "couple weeks" prior to September 6, 2025, the G talked with the SP and the SP said that s/he and the VA did not "get along." The G told the SP that s/he needed to give the VA time as s/he takes time to get to know the SP.

P3 provided the following information:

- P5 told P3 that as the SP was leaving, the SP was "tapping" on the walls and the glass on the front door. The VA responded to the "tapping" by hitting his/her head onto the walls and front door (note: P3 did not say when s/he was notified by P5, but the incident report completed by P5, said that P3 was notified on September 10, 2025, at 3:30 p.m.).

- Staff persons were trained to redirect the VA verbally and if the VA was "headbanging" to place "something soft" between the VA's head and the object s/he was hitting with his/her head. Staff persons were to try and "cheer" the VA up and/or try to get the VA to do something else when the VA engaged in self-injurious behavior.

- The VA had a history of seizures and falls. If the VA was "happy" or "mad," the VA may run into walls or trip and fall. The VA would have scratches on his/her face from the VA scratching him/herself. The VA would get bruises on his/her shoulders and on the side of his/her hips from seizure related falls.

The SP provided the following information for the facility's internal review:

- On an unknown date, the SP assisted the VA with a bath and had a "tough time." During the bath, the VA bit the SP on the shoulder. The VA was "upset" during the day. The SP denied doing "any action" that would have caused the VA to become more upset.

- The SP worked with P5 at a previous job and though that P5 was "out to get [him/her]."

Facility personnel and training records showed that P1-P7, and the SP were all trained on the Reporting of Maltreatment of Vulnerable Adults Act. P3-P6 and the SP were trained on the VA's plans. P1 and P2 were administrative staff that did not work directly with the VA. The facility did not have documentation that P7 was trained on the VA's plans.

Relevant Rules and Statutes:

Minnesota Statutes, section245D.04, subdivision 3, paragraph (a), clause (6), stated that a person's protection related rights include the right to be treated with courtesy and respect

Conclusion:

Regarding the SP taunting and upsetting the VA:

While there were different dates provided by multiple staff persons and documentation, P5, who was present for the incident, told this investigator that on September 6, 2025, as the SP was leaving his/her shift around 5 p.m., the SP was "taunting" the VA. P5 was in another individual's room when s/he heard the SP and the VA "interacting" and then heard the VA "headbang" the wall. The SP waved and said, "Goodbye [the VA]." The SP continued to say "bye" and backed down the hallway with the VA following. As the SP was leaving out the front door, the SP asked the VA if s/he wanted to "slam the door" which the VA then hit the front door. The SP went outside and waved at the VA through the front door window. The VA hit his/her head on the front door and continued to do so until P5 made a "shoo" gesture through the window and the SP left the facility. The SP denied doing "any action" that would have caused the VA to become more upset.

It was likely that the SP engaged in behavior that was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and a violation of Minnesota Statutes, section 245D.04, subdivision 3, paragraph (a), clauses (6). However, given that there was no information that the SP taunted the VA more than one occasion, there was not a preponderance of the evidence whether the SP's conduct rose to the level of emotional abuse or whether the SP's conduct produced emotional distress.

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.)

Regarding bruises being found on the VA's shoulder following a shift that the SP worked with the VA:

Although the VA sustained bruises on his/her left shoulder and it was discovered after a shift that the SP assisted the VA with a shower, there was a documented fall on September 6, 2025, and two suspected falls on September

7, 2025, that were heard but not observed by staff persons. The VA also had bruises on his/her right thigh, a bruise and red mark on his/her left elbow, and a scratch on his/her left ankle which were in places the VA had previous injuries from falls. While P6 said s/he heard the VA "scream" when the SP and the VA were in the bathroom, the VA used vocal cues for multiple reasons and P6 thought the "scream" may have been to express that s/he did not want to take a shower.

Given that the VA had three suspected or observed falls on September 6 and 7, 2025, had a history of bruising/injuries after falls, and that the SP and the VA were alone in the bathroom when the SP assisted the VA with a shower and the SP denied hurting the VA, it was not able to be determined when or how the VA sustained the various bruises/scratches/red marks. Therefore, there was not a preponderance of the evidence whether the SP engaged in conduct that would be reasonable expected to produce pain or injury or whether the VA's injuries were caused by means other than accidental.

It was not determined whether physical 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).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but were not followed by the SP when the SP caused "negative actions to [the VA]." The "incident was discussed with other staff on ways to communicate" with the individuals served by the program and "ways to deescalate." The SP no longer worked at the facility.

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.

The facility was issued a Correction Order for not documenting staff training as required.