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: 202509099

Date Issued: February 2, 2026

Name and Address of Facility Investigated:

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

JEC Miller Inc
4361 West 144th Street
Savage, MN 55378

JEC Miller Inc
7300 Metro Blvd #355
Edina, MN 55439

License Number and Program Type:

1117392-H_CRS (Home and Community-Based Services-Community Residential Setting)
1090632-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) engaged in a power struggle with a vulnerable adult and held the VA during the incident. The VA later had bruises and injuries.

Date of Incident(s): September 26, 2025

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b); and Minnesota Statutes, section 626.5572, subdivision 15; subdivision 2, paragraph (b), clauses (1) and (3); 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.

- Use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

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, 2025; from documentation at the facility; and through five interviews conducted with a supervisory facility staff person (P1), two facility staff persons (P2 and P3), the VA's guardian (G) who was also a family member, and the SP. This investigator met with the VA, but the VA was unable to provide information related to the investigation.

The VA was diagnosed with a seizure disorder, vertigo, autism, and anxiety. The VA's family was very important to him/her and the VA liked doing puzzles, being out in the community, and watching TV. The VA lived at the facility with three other clients who had all lived there for approximately 20 years. The facility was split level with four half-levels. The VA's bedroom was at the top level at the end of the hallway. The living room, kitchen, and dining area were on the main floor with a TV and common area half a flight down. There was a half-wall between the main level into the common area. Another half-flight down from the common area was an office and laundry space.

The VA's plans stated that when s/he got anxious, frustrated, or upset, staff persons could "offer to engage [the VA] in a social story when it applies to what is happening in the moment." Staff persons were to also "physically intervene to block" the VA from harm and remove the VA from the situation by bringing the VA to a neutral area. The VA also had an as needed medication (PRN) for helping with "escalating" behaviors. Staff persons were to offer "cerebral cues to calm" the VA and ask the VA to use self-calming techniques. Staff persons were also to "physically intervene and place themselves between" the VA and harm.

The G and P1 provided the following information:

- According to the G, on September 28, 2025, at about 10:35 a.m., while the VA was on a visit with the G, the G saw "fading" bruising on both of the VA's upper shins which continued to the lower knees. The G notified P1. The right leg bruise was approximately three inches in length, and the left leg bruise was approximately five inches in length. The VA's right knee also looked swollen. The VA did not receive medical attention for the injuries. The G took photos of the VA's knees and sent them to P1. P1 was unaware of any injuries to the VA's knees prior to this.

- P1 stated that the VA returned to the facility later that day, on September 28, 2025, and the following morning, when s/he arrived at the facility, s/he looked at the VA's knees and then also noticed a bruise on the VA's left inner arm above the elbow. The bruise was a "huge, multi-colored" bruise, brown, yellow, and black, and looked like the VA's skin was "scabbing over." The bruise was circular and approximately two inches in diameter. P1 took a photo of the VA's inner left arm area.

- According to the G, the VA could not "communicate well" and had difficultly providing other information but could answer questions in the form of yes or no phrasing, and when given a choice, could make a selection.

- According to the G and P1, P1 asked the VA which arm hurt. The VA pointed to his/her left arm. P1 showed pictures of each staff person to the VA and asked the VA who gave the VA an "ouchie," and the VA said, "No," to every staff person, except said, "Yep," and "Ew," when the SP's picture was shown. P1 repeated this several times spaced throughout the day, and the VA identified the SP each time, saying, "No," to all other staff persons.

- September 29, 2025, was the next time P1 saw the VA after the VA returned from the G's house. P1 asked staff persons if they had seen injuries on the VA and no one had seen anything, but after more questions P2 told P1 that the VA had "behaviors" on the evening shift of September 26, 2025, at medication time while working with the SP. P2 told P1 that s/he was helping other clients during that shift and that the SP was working with the VA. After the evening medications, the VA and SP went to the VA's bedroom. The SP shut the door to ready the VA for bed, and P2 said that s/he heard a bunch of "swearing" and "yelling" from the VA. P2 told P1 that s/he could tell that a "power struggle" was going on, but did not witness anything him/herself because the bedroom door was closed. P2 yelled to the SP, offering help, but the SP declined P2's offer.

- The SP told P1 that s/he prevented the VA from leaving the VA's bedroom that night and "put the VA on the floor" and was "holding the VA" on the floor so s/he would not "bite" him/herself, which may have caused the arm bruise. This likely made the situation "worse."

- P1 asked the SP if s/he thought the incident had been the cause of the bruising on the VA's knees and the SP stated that the VA did not let the SP look at the VA's knees during or immediately after the incident.

- According to the G, when s/he observed P1's photograph of the VA's arm injury, the G said that the injury looked like a "bite" mark or possibly from fingernails. The later G "manipulated" the VA's arm to see if the VA bit him/herself, but there was "no way" the VA could have bent his/her arm in that way. The G did not see this when s/he was with the VA on the overnight visit.

- P1 stated that staff persons did not see any bruising on the VA on September 27, 2025.

Progress notes for September 27 and 28, 2025, did not show any information about observed markings or bruising, however progress notes for the evening of September 28, 2025, entered by P2 stated that the VA did not want to change into his/her pajamas that evening and at the time the progress note was written at around 10 p.m., the VA was still in his/her day clothes.

P2 provided the following information:

- On September 26, 2025, P2 was working with the SP in the evening and the VA was having a "behavior," in the common area. The VA sometimes "threw" things, but this time, the VA "pushed" his/her dinner plate of food off the table. The plate broke when it hit the floor, and the sound alerted P2 to the behavior, who was not in the common area with the VA but was helping other clients on the main level. Typically, medications were given to the VA a little after 7 p.m., prior to bedtime, and this was when the incident happened. In general, staff persons had until 8 p.m. to give medications. On weekends, evening medications were "always" given late because the VA knew that bedtime followed medications and it was difficult to get the VA to take medications on weekend nights, when s/he stayed up a little later.

- The VA often got "frustrated" during medication times or bedtime, or sometimes for "no reason." Typically, when the VA had a behavior, one staff person would work with the VA and the other staff person would assist the other clients. P2, who was a half a flight up, in the living room, checked on the SP and VA, and went back to assisting the other clients. The SP and the VA went upstairs to the VA's bedroom and shut the door. P2 did not see the VA for the rest of the evening.

- At some point while the VA and SP were in the VA's bedroom, P2 heard the VA yell, "Go away." The VA yelled "a lot," but this evening the VA was "more vocal." Even so, P2 stated this was "not unusual," and it did not "concern" P2. P2 also heard a door "slam" and a "boom, boom" pounding noise that the VA sometimes made when s/he "hit" the door after it shut. P2 did not see "anything unusual" with the SP's interactions that evening and did not think the VA was "getting hurt." P2 denied hearing any "wrestling" between the SP and the VA while in the VA's room, and P2 did not ask the SP about the interactions that evening. P2 did not see any markings or bruising on the VA until they were pointed out by P1 on a later date.

- Staff persons were not supposed to "hold" clients. They were supposed to "back out" or back away from them. P2 had "never" seen the VA self-harm, to include biting, "throwing" him/herself on the ground, or hitting him/herself.

The SP provided the following information:

- On September 26, 2025, the SP was working with P2, and at around 9 p.m., told the VA that it was time for bed. The VA refused medications earlier in the evening. The SP turned off the TV and the VA threw the TV remote at the SP, who "ducked" out of the way. The SP "guided" the VA up the stairs and to his/her bedroom. In the past, the VA had locked him/herself in other clients' bedrooms, so to avoid that, the SP stood inside the VA's bedroom, at the door. When the SP got inside the VA's bedroom, the VA began to throw items at the SP and push a chair at the SP, so the SP "grabbed" the VA's hands and "held" the VA's wrists with the SP's hands. The VA dropped to the ground on his/her knees, so the SP and the VA were both kneeling on the floor, leaning forward on the VA's bed. The SP was behind the VA, giving the VA a "bear hug" while holding the VA's wrists. The SP then got the VA up onto the bed and asked the VA if s/he was going to "relax" and "chill." When the VA said, "Yes," or "Okay," the SP would release the VA. The SP "held" the VA for "a few seconds" and then let the VA go.

- Several seconds later, the VA attempted to get out of bed and the SP put the VA in the same position, on the floor, kneeling next to the bed, and then "gently" put the VA back on the bed "without harming" the VA. This happened two times and then the VA "got tired" of trying to get up and went to bed. At certain points, the VA was "forcefully" trying to leave the bedroom. When the VA would try to come out, the SP would "push" the VA back into the room. The VA stopped trying to leave the room at about 11 p.m. The SP also stated that it took approximately 90 to 120 minutes to get the VA in bed for the evening when they began the bedtime routine at about 9 p.m. During the latter portion of this time frame, after the VA and SP were on the floor and next to the bed, the SP stood outside of the VA's bedroom door to deter the VA from attempting to come back out.

- When the SP held the VA's hands or wrists, the VA would sometimes attempt to bite the SP's hands or neck, and would sometimes miss, resulting in the VA biting his/her own hands. The SP held the VA's wrists and hands to prevent the VA from biting him/herself. The SP stated that s/he felt like the VA was in "imminent danger" to him/herself and to the SP by "throwing" things and attempting to bite the SP and him/herself. The SP provided conflicting information on whether the VA bit him/herself that night, stating to the facility that the VA bit him/herself and to this investigator that the VA did not bite him/herself. There were not bite marks on the VA's hands, but the VA attempted to bite the SP on the hands and on the neck. The VA attempted to "throw" him/herself to the floor so the SP was "holding" the VA so that the VA would not "throw" him/herself and hurt him/herself. The SP also did not want the VA to throw things and make his/her bedroom "messy."

- The SP admitted to "holding" the VA's arms, later described as the wrists for approximately 10 to 20 seconds, so that s/he would not bite the SP or him/herself. The SP stated that s/he grabbed the VA at about a "one to a two" on a scale of zero to ten, with ten being the hardest to grab a person. The SP stated that the VA was "resisting" during the times when the SP physically "held" the VA. The SP denied grabbing the VA on the upper arm area but stated that the upper arm injury maybe could have happened when the VA "threw" him/herself on the ground.

- The SP was trained to "hold" the VA "from the back" like a "bear hug" so that s/he could not bite the SP on the neck or shoulders. Staff persons were supposed to make sure the VA did not come out of his/her bedroom at night. The SP was following what P1 asked of staff persons.

- The SP denied any interactions with the VA that would have caused the VA's knees to "bleed." No one had shown the SP any pictures of the VA's injuries to the legs, knees, or arms. The SP admitted that the VA could have gotten "rugburn" on his/her knees from the clothing or carpet rubbing on the VA's knees when the VA and the SP were kneeling on the floor next to the VA's bed. The SP "doubted" that any touching or holding of the VA's arms by the SP would have caused bleeding or bruising because the SP held and controlled the VA's hands in a manner which kept the VA from biting him/herself.

P1 provided the following additional information:

- Administering medications to the VA was only challenging if the VA was not comfortable with a staff person and there had been "repetitive instances" when the VA was "tense" around the SP due to the SP's approach. It was "very obvious" that the VA was "standoffish" toward the SP and wanted the SP out of his/her "space."

- The SP told P1 that s/he "held" the VA for under 60 seconds, which P1 said was an "allowed" amount of time. P1 later provided additional information that a "hold" would be allowed under "emergent" situations to prevent the VA from "imminent" danger to him/herself or others such as severe weather, fire, or the VA running onto a busy street. The SP should have documented the hold, but the SP did not. The facility held "extensive trainings" on how to approach and work with the VA. It had been "very clear" to not engage in "power struggle" with the VA due to his/her "anxiety." The VA had the freedom to move "freely" at the facility and refuse medications.

- The SP should have given the VA "space" and in the years that P1 worked with the VA, staff persons had "never put a hold" on the VA. P1 had never seen the VA "throw" him/herself to the ground. If the VA wanted to leave his/her bedroom, staff persons were to let the VA leave and get out of the VA's way when s/he got "physically aggressive."

- P1 denied telling the SP or any staff that the VA could not come out of his/her room in the evenings.

P3 provided the following information:

- On Monday morning, September 29, 2025, P3 was assisting the VA with cares and noticed an "injury" to the VA's left inner arm. P3 notified P1 immediately, but P1 was already aware. The injury was "red" and "less than a quarter" in size, but P3 could not say exactly the size, but using his/her fingers, demonstrated a width of approximately one quarter of an inch to three eighths on an inch. It was not bleeding and looked like a "scratch." P1 told P3 about the VA's knee bruises, but P3 could not really see the bruising to the knees.

- P3 later heard that the VA's arm injury was due to the SP "holding" the VA. Staff persons did not "restrain" the VA at this facility. The VA did not like to be touched, and P3 assisted the VA with cares most days. The VA knew that s/he would be touched when P3 assisted the VA with cares and P3 taught other staff persons to talk to the VA while assisting with cares because it made it easier for the VA.

- P3 had never seen the VA "throw" him/herself on the floor or engage in self-harming behaviors such as biting, and P3 had worked with the VA for over a decade. The VA did well when s/he knew what to expect out of the day and what activity was happening next and after that, and so on. It made "transitions" easier for the VA and for staff persons when the VA knew and looked forward to the next activity.

All staff persons interviewed for this report were trained on the Reporting of Maltreatment of Vulnerable Adults Act, Crisis Prevention Intervention training, which included the Emergency Use of Manual Restraints training, and the VA's plans.

Conclusion:

A. Maltreatment:

Information from P2 and the SP showed that on September 26, 2025, the SP was working closely with the VA in the evening and that the VA began having behaviors which included throwing things. The SP and the VA then went upstairs to the VA's bedroom and shut the door. The SP stated that at around 9 p.m., the SP "guided" the

VA up to his/her bedroom for the evening. P2 did not see the VA for the rest of the evening. At some point while the VA and SP were in the VA's bedroom, P2 heard the VA yell, "Go away." P2 also heard a door "slam" and a "boom, boom" noise that the VA sometimes made when s/he "hit" the door after it shut. P2 did not see "anything unusual" with the SP's interactions that evening and did not think the VA was "getting hurt."

The SP stated that once in the VA's room, the VA continued to attempt to throw things at the SP and kept trying to leave the bedroom. The SP "grabbed" the VA's hands and "held" the VA's wrists with the SP's hands. The VA dropped to the ground on his/her knees, so the SP and the VA were both kneeling on the floor, leaning forward on the VA's bed. The SP was behind the VA, holding the VA in a "bear hug" while holding the VA's wrists. The SP perceived the VA to be in "imminent danger" to him/herself and to the SP by "throwing" things and attempting to bite the SP and him/herself. The SP provided conflicting information stating to the facility that the VA bit him/herself that night and to this investigator that the VA did not bite him/herself that night, nor were there bite marks on the VA's hands. The VA attempted to bite the SP on the hands and on the neck after the SP physically intervened. The SP admitted to "holding" the VA's wrists for approximately 10 to 20 seconds, so that s/he would not bite the SP or him/herself. The SP stated that when the VA attempted to get out of bed the SP held the VA in the same position and put the VA back in bed. This occurred two times until the VA was tired and did not attempt to get out of bed again. The SP also stated that at some points during the incident the VA tried to forcefully leave the room, but the SP "pushed" the VA back in and did not allow him/her to leave. The SP stood outside the VA's door so the VA would not come back out.

According to the G, on September 28, 2025, during an overnight visit with the VA, the G saw "fading" bruising on both of the VA's upper shins which continued to the lower knees. The VA's right knee also looked swollen. The G took and sent photos of the injuries to P1.

According to P1, on September 29, 2025, when P1 next saw the VA, P1 also noticed a bruise on the VA's left inner arm above the elbow and took a photo. The VA identified the SP as giving the VA an "ouchie."

The VA's plans stated that staff persons were to try to talk to the VA, calm the VA, or offer a PRN during the VA's "escalating" behaviors. Staff persons were also to "physically intervene" by placing themselves between the VA and possible harm.

Although the SP stated the VA was at risk of harm to him/herself and the SP so the SP restrained the VA, the VA did not have injuries on his/her wrists where the VA held the VA, and the VA's injuries were not discovered until two days after the incident, given that the SP physically intervened after a short period of time when the VA was only pushing objects rather than moving away from the VA and using less restrictive interventions engaging in a power struggle continuing to physically intervene; that the SP held the VA's wrists a second time when the VA wanted to get out of bed and the SP put the VA back into bed; and that the SP blocked the VA from leaving his/her room more than once by "pushing" the VA back into the room and standing at the door confining the VA to his/her room, there was a preponderance of the evidence that there was a failure to provide the VA with reasonable and necessary care and services and that the SP used a deprivation procedure and confined the VA which was not accidental.

It was determined that neglect and abuse 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; 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 or use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544).

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.

The SP was trained on the VA's plans and on the Reporting of Maltreatment of Vulnerable Adults Act. 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 and abuse for which the SP was responsible did not meet statutory criteria to be determined as recurring because it was a single incident or serious because the VA did not require the care of a physician and because it was not determined what caused the VA's injuries.

Action Taken by Facility:

The facility's *Internal Review* stated that the policies and procedures were adequate but were not followed. There was no need for additional training because the SP no longer worked for the facility, and the facility implemented a corrective action plan, designed to correct current lapses and prevent future lapses in staff person performance.

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.