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: 202508412

Date Issued: February 6, 2026

Name and Address of Facility Investigated:

Actively Living Life Inc 605 Home
605 Johnson Avenue SW
Cokato, MN 55321

Actively Living Life Inc
13052 170th Street
Glencoe, MN 55336

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

License Number and Program Type:

1099856-H_CRS (Home and Community-Based Services-Community Residential Setting)
1096217-HCBS (Home and Community-Based Services)

Investigator(s):

Heidi Murphy
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
Heidi.Murphy@state.mn.us
651-431-6544

Suspected Maltreatment Reported:

It was reported that after a physical altercation between a vulnerable adult (VA) and a housemate, the VA made a statement that s/he and a staff person (SP) "fight like this" and the SP responded that "physical fighting" was a part of the VA's care plan.

Date of Incident(s): Ongoing.

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 (1); 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.

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 3, 2025; from documentation at the facility and law enforcement records; and through seven interviews conducted with the VA, facility staff persons (the SP, P1, P2, and P3), a facility resident (R1), and the VA's guardian (G).

The VA's diagnoses included psychosis, autism, depression, and anxiety. The VA enjoyed watching horror movies and anime and playing video games.

The facility was a one-story single-family residence in a residential neighborhood. The main floor consisted of three bedrooms, a bathroom, a kitchen, a dining room, and a living room. The basement had the VA's bedroom, a bathroom, a utility/laundry room, and a living room.

The VA's *Self-Management Assessment* stated, "[The VA] enjoys roughhousing with staff and others but does not always understand [his/her] own strength and has accidentally hurt others. [The VA] has never had an issue stopping or toning it down when asked but requires supervision to ensure [s/he] does not accidentally cause harm." Under the "permitted actions" portion of the VA's *Support Plan Addendum – Intensive Services,* it stated on a "continuous basis," the VA required the "use of permitted actions and procedures that includes physical contact or instructional techniques to calm or comfort a person by holding that person with no resistance from the person. [The VA] enjoys wrestling and roughhousing with staff. This helps [the VA] stay regulated and benefits [his/her] overall mental health." The VA's *MnCHOICES Assessment* stated the VA had several behaviors that included harm to self, harm to others, harm to property, impulsiveness, and agitated, heightened irritability, quick to anger/temper and were all classified as "very severe." The VA's *IAPP* stated the VA was susceptible to physical abuse due to the inability to identify potentially dangerous situations, inappropriate interactions with others, the inability to deal with verbally/physically aggressive persons, and the VA had been verbally/physically abusive to others. The VA got agitated and became physically violent and was unable to distinguish between good feelings and bad feelings.

The VA provided the following information:

- The VA was "chunky" when s/he moved into the facility and staff persons made the VA "workout." The SP said the VA was his/her "pet project" and tried to make it so the VA would not get angry over things that previously upset the VA.

- The VA and the SP interacted by "roughhousing." The VA stated several years ago, the VA had an "episode" and the SP "tried to get on [the VA's] back" to restrain the VA. The VA recalled other incidents in which the VA "lifted" the SP up and "threw" the SP to the ground, the VA kneed the SP in the back and the SP dropped to the ground, and the VA "tackled" the SP and the SP "slapped" the VA on the ear.

- When asked to describe the roughhousing with the SP, the VA stated, "We just beat each other." The SP punched the VA in the "liver," the lower right abdominal area, with a closed fist. The VA stated, "it might be hard for other people, but not me" when the VA referred to the SP hitting the VA. The VA stated it "hurt" when the SP hit him/her and added that the VA "took so many liver shots, it doesn't really hurt anymore."

- Other staff persons "goof around" with the VA and "mainly" same gender staff roughhoused with the VA. The VA stated it depended on his/her mood if the roughhousing bothered him/her.

Law enforcement records showed that on September 10, 2025, a law enforcement officer (LEO) went to the facility when the VA and the housemate had a physical altercation. The VA punched the housemate "in the gut" and banged the housemate's head against the wall two times. The VA told the LEO that s/he believed this behavior was "normal" because the VA and the SP "fight like this." The SP told the LEO that the "physical fighting" the SP did with the VA was part of the VA's care plan because it "calms" the VA.

P1 provided the following information:

- The VA was very honest with everything and was able to provide reliable information. The VA did not show emotion and was not able to tell if others were joking around.

- The SP had a history of punching and hitting the VA. In the spring of 2024, the SP tried to get the VA to work out by running around the block. The VA was afraid of water and the SP chased the VA with the hose to make him/her run. The VA told P1, P2, and P3 about a time that his/her legs hurt and the SP said, "I'll give you a reason for your legs to hurt," and hit the VA in the legs with a baseball bat. The SP "smacked" the clients around and tried to get them to exercise. The SP brought his/her own "BB guns" or used a client's BB guns and shot at the VA and other clients. There were holes in one client's bedroom door from the SP shooting the BB guns. The VA had bruises on his/her arms on days the SP brought BB guns to the facility. P1 never asked about the injuries and stated, "I knew who was working that day, so I'm not assuming but assuming at the same time."

- The SP said, "It's in [the VA's] plans to roughhouse." P1 felt the roughhousing was "very questionable" and questioned if it was abuse. P1 witnessed the SP punch the VA in the liver, shove the VA, and grab the VA's hoodie and pull it over his/her head and then punch the VA in the stomach.

- P1 had not witnessed any other staff person physically touch the VA.

- P1 thought the VA was bothered by the interactions with the SP. The VA did not engage in roughhousing with the SP and it was not mutual. The VA did not show emotion and P1 told the VA that the SP had to stop if the VA told the SP to stop. The VA never raised a hand to any staff person and did not hit the SP back. P1 did not think the VA understood what the SP was doing.

- The VA said another client "can't take a liver shot like I can take a liver shot from [the SP]." All staff persons observed the SP hit the VA and were told it was in the VA's plans to roughhouse. The SP punched the VA in the stomach "all the time" and had shoved the VA's head a "few times." Concerns had been brought to P3 and P3 was not sure if it should be reported based on roughhousing being in the VA's plans.

P2 provided the following information:

- The VA was "very honest." The VA had a hard time expressing and showing emotions. The VA did not understand the difference between joking around or being mean.

- No other staff roughhoused with the VA like the SP did. The SP said it was in the VA's plans that roughhousing was allowed. P2 did not recall seeing the VA's plans. Staff persons joked with the VA but the SP was the only staff person that "physically roughhoused" with the VA. The roughhousing looked like wrestling but was "more intense." The SP got the VA in a chokehold when the VA sat on the ground. The SP initiated the roughhousing. P2 stated the SP "goes too far" when roughhousing with the VA. P2 was concerned the SP would hurt the VA and cause the VA to have negative behaviors and "destroy the house" and then other staff persons would have to deal with the aftermath.

- The VA seemed to enjoy the roughhousing in the moment. After the SP left, the VA told other staff persons that s/he did not care for the roughhousing all the time. The VA seemed frustrated that the SP did not roughhouse with the other clients the way the SP roughhoused with the VA. The VA said it was because the VA was "bigger and tougher and can take it better." The roughhousing looked like it was joking around about half the time and the other half if looked like "abuse" and was "pretty rough." P2 stated it looked like the SP was being mean to the VA intentionally and "played it off as a joke."

- The SP and the VA punched each other. The VA said the SP "hits [the VA] hard." When the VA hit the SP, it sounded "pretty hard." The VA never asked the SP to stop but other staff persons told the SP to stop. P2 told the VA to tell the SP to stop if s/he wanted the behavior to stop. The VA said, "All I have to do is say stop?"

- The SP had the VA participate in an intense workout program that included pull-ups, sit-ups, burpees, and running. P2 thought the program was too intense for the VA and brought concerns to the SP's supervisor, who agreed the program should not be done every day like the SP was making the VA. The VA said the workout routine was too intense.

- P2 did not feel the clients should have air soft guns, and a bow and arrow that the SP bought for the clients. The VA made comments about wanting to shoot another client and P2 did not feel it was a good idea for the VA to have access to those weapons.

- The SP was not always nice to the VA. The SP told the VA to "stop shaking" when shaking was caused by the VA's diagnoses.

P3 provided the following information:

- The VA was "brutally honest" and was able to provide reliable information.

- The VA said the SP gave him/her "liver shots" (punches to the liver) and P3 stated that was "more than roughhousing."

- The roughhousing got "pretty intense" and "sometimes it's just mean." The SP roughhoused with the VA every time the SP was at the facility. The roughhousing was always initiated by the SP. P3 stated the SP hit and punched the VA during the roughhousing. Sometimes the interactions looked like roughhousing and sometimes P3 thought the SP was "being a jerk." Staff persons did not know what to do because they were told the roughhousing was in the VA's plans.

- The VA used to enjoy the roughhousing but now complained about it. When the SP left after roughing with the VA, the VA complained about the SP "always messing" with him/her and that the SP "doesn't mess with anyone else." The VA said the SP hit him/her "hard." It looked like "how [siblings] fight." The SP used to try to roughhouse with another client but does not anymore. No other staff persons roughhoused with the VA.

- The SP called the VA "fat." When the VA asked for extra food or wanted "sweets", the SP said, "Do you need that? Look at yourself in the mirror, do you really need that?" The SP said s/he was helping the VA.

- A lot of staff persons voiced concerns over the physical interactions the SP had with the VA and the workout routine the VA was doing. The workouts were like a "boot camp." The SP made the VA run around the block. Every staff person complained about how intense and excessive the workouts were and they did not stop until a State of Minnesota employee was at the facility and stated electronics could not be withheld until workouts were completed.

- The VA told staff persons, including P3, that the SP hit him/her with a baseball bat and the VA said, "You don't see me crying." The VA also stated the SP had woken the VA up by hitting him/her with a wooden sword in the VA's bedroom.

- The VA was shot by another client with a BB gun in the forearm and it broke skin. P3 did not think the clients should have those types of objects at the facility.

The G was aware that the VA "roughhoused" with the SP but believed it was similar to wrestling and was "goofing around." The G was not concerned with the roughhousing and believed the VA enjoyed it. The G did not think roughhousing was addressed in the VA's plans and felt the roughhousing was the "dynamics" of the house. The G did not have any concerns with the facility or with staff persons.

R1 did not observe roughhousing at the facility and did not have any concerns about the facility or staff persons.

The SP provided the following information:

- The SP slapped and punched the VA and engaged in boxing with the VA. The SP would "catch [the VA] on the cheek" or "in the gut" if the VA was "leaving [him/herself] open" and not "guarding" to prevent it. The SP admitted s/he "smacked" the VA in the liver and the VA "definitely felt it." The SP denied that s/he ever got hurt and stated the VA never got hurt. The VA "got pretty into it a couple times" and the SP had to tell the VA to stop.

- The SP only "roughhoused" with the VA, which was a permitted action in the VA's plans. The VA liked "wrestling around and pushing back and forth." The VA was a "special case," and the SP did not roughhouse with other clients. A "typical roughhousing session" involved bumping and pushing each other and grabbing each other's arms. The SP "picked on" the VA and would "push on [his/her] shoulder" while the VA was engaged on a tablet. If the VA asked the SP to stop, the SP stopped.

- The clients were allowed to use airsoft guns, and the VA had a bow and arrow set. The clients "run around and shoot each other" with the airsoft guns. Knives were kept locked in a closet and the VA had access to the knives only when the VA needed them and then they were "returned for the safety of everyone."

- The SP bumped into the VA to initiate "roughhousing." The SP stated the VA enjoyed roughhousing. The SP understood "where that probably becomes borderline whether it is or isn't maltreatment." The SP would not do "that stuff" with the VA if it was not allowed.

- Staff persons raised concerns over the SP roughhousing with the VA. The SP believed a staff person made a report years ago after the SP "bonked" the VA on the head with a broken part of a chair, while the VA had a bike helmet on. The SP stated, "You couldn't do this with every [client] but [the VA] really thrives on this kind of stuff." The SP stated s/he has always been very open about how s/he was "picking on" and roughhousing with the VA and the benefits s/he had seen from it.

- The VA was the SP's "project." The SP spent more time with the VA than other residents. The SP viewed his/her relations with the VA as "unique" and did not feel they were inappropriate. The SP stated the roughhousing "rides a very fine line/grey area" and acknowledged staff persons were generally "not supposed to do that with clients."

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

Conclusion:

A. Maltreatment:

Information from P1, P2, and P3 showed that there were multiple concerns with the SP's interactions with the VA. P1, P2, and P3 provided information that on unknown dates, the SP was observed pushing, shoving, hitting, punching the VA, forcing the VA to exercise, and chasing the VA with a hose and spraying water at the VA so the VA would run. The VA told staff persons of other such incidents that were not observed by P1, P2, or P3, that included the SP hitting the VA with a wooden sword and a baseball bat. P1, P2, and P3 were told "roughhousing" was in the VA's plans, which allowed the SP to have the physical interactions with the VA.

The VA provided information that the SP punched and hit the VA on several occasions and that the SP and the VA "beat each other." The VA stated it hurt when the SP hit him/her, but the VA had taken so many "liver shots" that it did not hurt anymore.

The law enforcement records showed that the VA told the LEO that s/he punched the housemate and banged his/her head against the wall because s/he thought it was "normal" because of how the VA and the SP fought.

The SP acknowledged that s/he had slapped, punched, and "boxed" with the VA. The SP stated the VA "definitely felt" the liver shots but denied the VA was ever injured. The SP stated s/he would not engage in the physical contact with the VA if it was not allowed in the VA's plans and the SP understood that the physical contact rode a "fine line/grey area" and "probably becomes borderline whether it is or isn't maltreatment." The SP was aware of at least one previous report made by a staff person over concerns of the SP's interactions with the VA.

The VA's plans stated, "[The VA] enjoys roughhousing with staff and others but does not always understand [his/her] own strength and has accidentally hurt others. [The VA] has never had an issue stopping or toning it down when asked but requires supervision to ensure [s/he] does not accidentally cause harm," on a "continuous basis," the VA required the "use of permitted actions and procedures that includes physical contact or instructional techniques to calm or comfort a person by holding that person with no resistance from the person. [The VA] enjoys wrestling and roughhousing with staff. This helps [the VA] stay regulated and benefits [his/her] overall mental health."

The G was aware that the VA "roughhoused" with the SP but believed it was similar to wrestling and was "goofing around." The G was not concerned with the roughhousing and believed the VA enjoyed it.

Although the VA's plans permitted physical contact and roughhousing with staff, given that the SP's actions went beyond those that a reasonable person would consider roughhousing and providing therapeutic benefit, that multiple staff persons witnessed the SP hit, push, shove, and punch the VA, that the VA voiced to staff persons that s/he did not always enjoy the roughhousing, that the SP stated that s/he punched and hit the VA including punching the VA in the liver which the VA "definitely felt it," and that the SP stated that s/he initiated the physical contact with the VA, 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's conduct was not accidental and would be reasonably expected to produce physical pain and injury.

It was determined that neglect and physical 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).

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 c16, 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 were each not "serious" maltreatment because each did not meet statutory criteria but were each "recurring" maltreatment because there was more than one incident of neglect and more than one incident of physical abuse.

The SP was disqualified from providing direct contact services.

Action Taken by Facility:

The facility's *Internal Review* stated policies and procedures were followed. However, the policies and procedures were not adequate. The SP "could benefit from additional training" and there was not a need for corrective action by the license holder to protect the health and safety of vulnerable adults. The VA's plans were updated to show only the SP and one other staff person could "play with the VA." The SP received additional training on how to "handle and play" with the VA.

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

The SP was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.