

**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:** 202506386 and 202507591

**Date Issued:** February 9, 2026

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive as to physical abuse  
and false as to emotional abuse.

Fourth Avenue Homes  
6275 Broadway Ave N  
Rochester, MN 55906

Fourth Avenue Homes  
328 5TH ST SW STE 5  
Wilmar, MN 56201

**License Number and Program Type:**

1123520-H\_CRS (Home and Community-Based Services-Community Residential Setting)  
1068742-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

Concerns were reported regarding how staff persons (SP1, SP2, and SP3) used emergency use of manual restraints (EUMR) when placing a vulnerable adult (VA) in a hold after the VA had aggressive behaviors during multiple incidents within the community including while the VA was visiting another residential program operated by a different license holder (Facility 2). It was also reported that during one of the incidents, the VA bit SP2's hand and SP2 responded by calling the VA a "dumb fuck."

**Date of Incident(s):** (202506386) July 17 and (202507537) August 19, 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 August 12, 2025; from documentation at the facility; and through nine interviews conducted with SP1, a supervisory staff person (P1), two administrative staff persons (P2 and P3), the VA's guardians (G1 and G2) who were also the VA's family members, the VA's mental health professional (MHP), a supervisory staff person from Facility 2 (S), and the VA's case manager (CM). Attempts were made via phone and certified mail to contact and interview SP2 and SP3, but neither responded to the requests. However, SP2 and SP3 provided information for the facility's *Internal Review* which was included below. Additionally, this investigator met with the VA but due to his/her diagnoses and limited communication, the VA was unable to provide information for this investigation.

The VA enjoyed dancing, hiking, listening to music, watching movies, and spending time with family members. The VA's diagnoses included autism spectrum disorder, chromosomal abnormality, developmental delay, apraxia of speech (a neurologically based speech disorder in which the brain had difficulty in planning and coordinating the muscle movements needed for speech), moderate intellectual disability, anxiety, depression, and obsessive-compulsive disorder. The VA had limited verbal communication but was able to communicate with others using gestures and communication services through his/her iPad.

On December 2, 2024, the VA moved into the facility seeking supports and services relating to his/her diagnoses that included health and behavior management, community integration, transportation, supervision, and assistance to complete "all" activities of daily living. Due to the VA's history and concerns with ongoing behaviors, the facility installed a surveillance system in the common areas of the home and in the VA's bedroom. The VA also had adaptive equipment installed into the facility's vehicle that included a "barrier" between the front and the back seating to maintain the safety of the VA and the safety of staff persons during transportations.

The VA was the only client who resided at the facility. The VA had 2:1 staffing 24 hours a day and had no unsupervised time in the facility or the community.

The VA's *Support Plan*, *Individual Abuse Prevention Plan*, *Intensive Services Assessment*, *Positive Support Transition Plan (PSTP)*, and *Functional Behavior Assessment* provided the following information:

- The VA had a history of emotional dysregulation; self-injurious behaviors; "obsessional thoughts;" physical aggression that included property destruction and "hitting, kicking, punching, pulling hair, pinching, biting, and throwing objects at others;" leaving without the supervision of caregivers; being

involved in incidents requiring the assistance of first responders; and “frequently” attempting to and/or entering unknown homes within the community using physical force or were not locked. The VA also had a history of “attention seeking” behaviors that included making non-emergency phone calls to 9-1-1; providing information about the VA’s health/safety that was “not always true” or consistent with what the VA was “actually feeling, wanting, and/or needing;” engaging in maladaptive behaviors to provoke a “predicted” or “desired” response; and “escalating” situations to a level where the VA thought G1 would respond to.

- When the VA felt “confused,” “agitated,” “anxious,” or “overwhelmed,” the VA engaged in maladaptive behaviors including physical aggression. Staff persons provided the VA with daily medications and utilized positive behavior supports, crisis planning, structure, consistency, and verbal cues to assist the VA in regulating his/her emotions and managing his/her behaviors. The VA was also prescribed an as needed (PRN) medication to help “calm” the VA during times when s/he was “agitated” or “anxious” and/or had “escalated” behaviors. Additionally, staff persons were to help the VA develop the social and emotional skills that would allow the VA to reach his/her goal of being able to participate in community activities which were “significantly reduced” and “limited” because of the VA’s history of “unsafe” and aggressive behaviors.
- The VA did not understand why s/he was not able to do or have things that the VA wanted including “constant” and “instant attention” from his/her family members but “mainly [G1]” which was a “major trigger” in “escalating” the VA’s behaviors. The VA had “compulsive” behaviors of trying to use his/her iPad to FaceTime family members “numerous times in a row” throughout the day and “quickly” became “upset” or “worried” if the VA’s calls were not answered “immediately.”
- During situations when the VA was “upset” and had aggressive behaviors, staff persons provided the VA with “targeted interventions” that included verbal redirection, offering the VA “preferred” or “calming” activities, and administering a PRN if appropriate. If attempts to “de-escalate” a situation were not successful, the VA “often” entered a “crisis stage” in which the VA displayed “loud vocalizations,” property destruction, and continued and “increased” physical aggression towards others who attempted to redirect the VA to a “safe” activity or location. If the VA’s behaviors were an imminent risk of physical harm to the VA and/or to others, staff persons were to respond with an emergency use of manual restraints (EUMR) procedure until the VA was able to “return to [his/her] calm stage” while using the least restrictive manner possible. [Note: During interviews, persons used the words restraint and hold when referring to implementing EUMRs.]

The VA’s *Rights Restriction* dated January 9, 2025, and the VA’s *Meeting Notes* dated July 14, 2025, completed by the VA’s care team which included the VA, G1, G2, the CM, and P1 provided the following information:

- Due to the VA’s history and ongoing behaviors, the VA did not have access to a phone or the ability to send/receive written or electronic communications. With staff assistance and supervision, the VA could attempt to video call his/family members throughout the day using his/her iPad, but the VA also had at least one scheduled phone call with a family member each day. Staff persons got the facility phone from a locked cabinet and dialed the phone number for the VA. The phone calls were made using a Bluetooth headset that the VA was provided while staff persons held the phone. After the call was completed, staff persons returned the phone to the cabinet. Additionally, the VA’s personal possessions and household items that posed a risk to the VA’s health/safety were also kept in a secure space and only accessible to staff persons.

- According to the VA's *Rights Restriction*, the VA was to "refrain" from calling emergency services for "non-emergency reasons" or "convince anyone else" to call 9-1-1 if there was not a "true emergency" and the VA was not in need of medical attention.
- The VA "struggled" in regulating his/her emotions and had the "most" behavioral incidents during/after spending time with his/her family members. Therefore, "all" community outings and visits with family members were to be scheduled with staff persons in advance so that it could be planned and communicated accordingly with the VA who was "most successful" when s/he was provided with consistent routines and adequate time to understand what was expected from him/her to participate in a planned activity. Additionally, it was important that staff persons had adequate time to make any necessary arrangements with others and/or to an environment prior to community outings that would maintain the safety of the VA and the safety of others while allowing the VA to "successfully" interact within the community.

The CM provided the following information:

- Prior to moving into the facility, the VA had consistent and "pretty extreme" behaviors that included physical aggression towards others, "especially" G1 who was the VA's "safe space;" leaving without the supervision of caregivers; entering homes within the community and then locking him/herself and the resident of the home inside until law enforcement (LE) responded; and engaging in "unsafe" behaviors that resulted in the VA having "limited" community/social interactions including the VA being unable to attend school in-person. The VA's behaviors also resulted in community members contacting LE and the county attorney's office "all the time" and "on a regular basis" about concerns relating to the VA's behaviors until the VA moved into the facility (December 2024).
- Around January or February 2025, the CM began working with the VA who had "a lot of growing pains" in adjusting to a new home and staffing at the facility but the VA and his/her care team were "recently" making "a lot of really good progress" as of "late August" in helping the VA better manage and regulate his/her emotions and behaviors, establishing "healthy" boundaries and expectations between the VA and his/her family members, and providing staff persons with "more effective" approaches and support in responding to the VA's behaviors. Furthermore, staff persons tried to refrain from using EUMRs that involved placing the VA into holds while the VA was on the floor and attempted to only place the VA into a hold while the VA was in a standing position. Staff persons were "doing their best" to then release the VA "right away" if the VA attempted to go to the floor on his/her own.
- The CM worked with the facility "for years" prior to the VA's placement and did not have any concerns with the care or treatment that the VA received from facility staff persons. The facility was a program "known to take in those more challenging clients" and "historically speaking," did a "good job" of meeting clients' needs while keeping "everyone on all sides" safe. Given that behavioral incidents involving the VA were not "new" concerns, occurred "frequently prior to the VA's placement at the facility, "consistently" occurred in "all" residential/community settings the VA was in, and were "recently" becoming less frequent and more manageable while under the facility's care, the CM was "confident" that the facility was the "best" setting and placement for the VA and "felt" there was not another living arrangement or "team of staff" who would be able to better provide the level of care that was needed to manage the VA's "complex" and "challenging" behaviors.

G2 stated that s/he was aware of the incidents and did not have any additional information to provide for this

investigation.

The facility's *EUMR Policy* stated:

- Staff persons were to use positive support strategies and techniques to attempt to “de-escalate” a client’s behavior before it posed an imminent risk of physical harm to the client and/or others. If these attempts were not successful, an EUMR might be necessary and used only when the following conditions were met:
  - Immediate intervention must be needed to protect the client and/or others from imminent risk of physical harm.
  - The type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety.
  - The manual restraint must end when the threat of harm ends.
- The facility allowed the following types of EUMRs:
  - “A Hold:” A staff person approached a client from behind and held the client’s arms down and to the sides of the client’s body by holding onto the client’s wrists, with the staff person’s hands over the client’s hands with “only” an amount of pressure needed to maintain the hold.
  - “B Hold:” A staff person approached a client from behind, held the client’s wrists, and crossed the client’s arms at the client’s waist level in a manner that the client’s elbows did not touch.
  - “C Hold:” Manual restraint on mat with one staff: A staff person approached a client from behind and used the “B Hold” while the staff person maintained an awareness of the environment and moved away from any furniture, walls, and/or other items that could cause harm to the client. The staff person then “buckled [the client’s] knees using [his/her] own knee, stepped back quickly, and took [the client’s] weight onto [his/her] body as [the staff person brought the client] from [his/her] feet to the mat.” The staff person then “gently eased” the client onto the floor and rolled the client to a side position while the client’s arms remained crossed at the waist level. Additionally, the staff person “should” maintain this position by placing his/her own body along the backside of the client’s body and “wrapping on leg around [the client’s] leg(s).”
  - “D Hold:” Manual restraint on a mat with two staff: A staff person “assumed responsibility of leadership,” approached a client from behind, and “safely” and “efficiently” performed a “C Hold” on the client while “clearly” directing a second staff person to help “secure” the client as needed in a manner that was “therapeutical” and used “good judgment.” The second staff person was also responsible for timing how long the client was placed within the hold.
- Staff persons were “prohibited” using an action that “might” restrict/obstruct a client’s airway or impair breathing, including techniques in which a staff person used his/her hands or body to place pressure on a client’s neck or applied pressure to a client’s chest who was in supine position (lying flat on his/her back).
- Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own did not constitute the use of an EUMR.

According to the facility's *HCBS Provider Attestation Policy*, clients had the right to be free from abuse and to be free from restraint, restrictive intervention, or other prohibited procedures, except in the case of emergency use of manual restraint to protect a client from imminent physical harm to him/herself or others. Additionally, clients were to have services and supports provided to them that were identified in their plans in a manner that respected clients as individuals and took into consideration the person's preferences. Clients were to be treated with dignity and respect.

According to the facility's *Program Abuse Prevention Plan*, the VA had a history of physical aggression towards others when the VA was "upset, confused, or otherwise unable to process feelings, thoughts, or environment" and the VA might leave the facility without the supervision of staff persons when s/he was "upset or agitated, often a result of confusion or denied access to something desired." Staff persons were trained on "effective" interventions to assist with and "handle" the VA's adverse behaviors including "various" de-escalation and redirection techniques, the facility's *EUMR Policy*, proactive and reactive strategies to reduce behaviors, and the VA's care plans.

Facility documentation showed that SP1, SP2, SP3, and P1 were trained on the VA's care plans; the facility's policies that included the *EUMR Policy*, the *HCBS Provider Attestation Policy*, and the *Program Abuse Prevention Plan*; and the Reporting of Maltreatment of Vulnerable Adults prior to the incident.

Regarding (202506386) incidents on July 17, 2025.

SP1, P1, P2, P3, and G1; the facility's *Incident Reports and Behavioral Intervention Reporting Forms*; and the facility's *Internal Review (IR)* completed by P1 and P2 including multiple "interviews" conducted with SP1, SP2, G1, and the MHP about the incidents provided the following information:

- On July 17, 2025, SP1 and SP2 worked at the facility during the dayshift with the VA. SP1 was a "regularly scheduled" staff person who worked with the VA Monday through Friday and every other weekend while SP2 "typically" worked at other programs operated by the same license holder and was "covering a shift" that day. Due to the VA's history and ongoing maladaptive behaviors, the VA "usually" attended meetings and appointments with his/her care team using video chat platforms including telehealth visits with the MHP. However, because of recent health symptoms the VA experienced, G1 requested an in-person visit and the VA's appointment was scheduled for 2:10 p.m. that afternoon. At approximately 2 p.m., SP1 and SP2 transported the VA from the facility to a local medical health clinic where they met G1 for the VA's appointment. SP1, SP2, and G1 remained with the VA and the MHP in a private room within the clinic for the duration of the appointment.
- The VA's appointment started "calmly" but at some point later the VA became "visibly anxious" and started to show "signs" of "escalating" behaviors such as lying on the floor and "refusing to cooperate" with G1 and the MHP. Around 2:30 p.m., the VA stood up from the floor, walked towards the door and where SP1 was sitting, "grabbed" SP1's hair, and started to aggressively "yank" SP1's hair. SP2 and G1 "immediately" approached the VA and SP1 while providing verbal redirection to the VA but the VA ignored these attempts, tried to "pinch" SP2, and did not let go of SP1's hair. Shortly thereafter, G1 and SP2 were able to "safely" place the VA into a "passive" hold (first restraint) for approximately two minutes until the VA "somewhat calmed down" and was no longer physically aggressive towards SP1. The VA then lay on the floor and began crying while G1 sat beside the VA trying to comfort him/her. G1 and the MHP continued to talk about the VA's health while G1 sat on the floor with the VA who "hugged" G1 and remained "calm" until the appointment concluded.

- After the VA's appointment, G1 interlocked his/her arm with the VA's arm as they left the MHP's office and exited the clinic through the main entrance of the building with SP1 and SP2. While walking on the sidewalk outside of the clinic towards the parking lot, the VA became "agitated" and started "pulling" G1 towards rock landscaping that was used throughout the clinic's exterior foyer and parking lot. G1 verbally redirected the VA and held both of the VA's arms and "calmly pulled" the VA away from the area but the VA "dropped" to the ground, "grabbed" SP2's leg, and attempted to bite SP2. "Following [G1's] lead," SP1 and SP2 also attempted to verbally redirect the VA but the VA ignored these attempts, tried to "crawl" towards the rocks, and continued to engage in aggressive behaviors that were "escalating" and becoming "unsafe" to the VA, G1, SP1, SP2, and community persons including a group of children who were "nearby."
- At approximately 3 p.m., G1, SP1, and SP2 placed the VA in a hold (second restraint) on the ground in supine position. G1 lay across the VA's chest/upper body while holding the VA's left forearm, SP1 held the VA's right arm, and SP2 was to the side of the VA holding the VA's left wrist with one hand and holding the VA's outer hip with his/her other hand. While helping hold the VA, G1 tried to verbally "comfort" and "calm" the VA, but the VA was "combative," "screaming," and continued to be aggressive towards SP1, SP2, and G1. At some point, about ten unknown healthcare staff from the clinic heard/observed the incident and came outside with blankets, mats, and umbrellas to help "shield" the VA and provide "privacy" to the situation because it was "drawing a lot of attention" from others in the area. One healthcare staff or another "bystander" observing the situation also approached the VA and placed an item under the VA's head for "comfort" and "safety."
- The VA remained in the hold for approximately 14 minutes during which time G1 talked to the VA saying that G1, SP1, and SP2 were going to "let go" of the VA so that G1 could walk to his/her car and get the VA's PRN. When they released the VA from the hold, G1 left to his/her car for the VA's medications and the VA "immediately" attempted to "hit, kick, and bite staff" so SP1 and SP2 implemented another EUMR (third restraint) using the "D Hold" while attempting to provide the VA reassurance and verbal redirection. Approximately four minutes later, G1 returned and administered the VA's PRN while SP1 and SP2 "relaxed their hold" as it "appeared" that the VA was "calming down a bit." Additionally, an unknown healthcare staff informed the MHP of the incident who then approached the situation while G1 was administering the VA's PRN.
- At approximately 3:18 p.m., G1, SP1, SP2, and the VA sat on the grass "catching [their] breath" and the VA "briefly relaxed" while G1 talked with the VA. About "a minute or two later," the VA "spun [his/her] body around" and kicked SP2 in the head/face and became "combative" and physically aggressive again. As outlined in the VA's care plans and "agreed upon" by G1 and the VA's team, G1 left the area at that point since the VA was "most aggressive" towards and around his/her family members, with the VA's behaviors further escalating during times when the VA wanted to remain with a family member "especially [G1]." After G1 left, the VA became more "upset," "combative," and physically aggressive, ignoring SP1's and SP2's attempts to "de-escalate" the situation by offering the VA preferred activities, breathing exercises, and reassurance.
- At approximately 3:30 p.m., SP1 and SP2 placed the VA in another manual restraint (fourth/final restraint) while the VA was in supine position on the grass with SP2 "straddling above" the VA's pelvic area and holding the VA's right arm while SP1 held the VA's left arm. The H and the MHP also remained outside to ensure the safety of the VA and the safety of others and again attempted to hold up various items to help "shield" the VA from the "public onlookers" and "families" that were nearby. The EUMR lasted for

approximately ten minutes. At some point during the hold, SP1 and SP2 started to become "fatigued" and "struggled" to maintain the EUMR while the VA "thrashed [his/her] body around." As the VA continued to try and "hit, kick, bite, and pinch" SP1 and SP2, the VA was able to "free [him/herself]" from SP1's hold and "immediately" rolled to his/her side away from SP1 and "bit down hard" on SP2's arm which "tore through" SP2's shirt and "broke [SP2's] skin." According to SP1, SP2 had a "human reaction to something painful" and "yelled out [...] aw, fuck" or "something like that" when the VA bit SP2's arm but SP1 did not recall SP2 "swearing" at or using "derogatory language" towards the VA at any point. SP2 told P2 that s/he did not recall what "exactly" was said when the VA bit SP2's arm but SP2 remembered that s/he "reacted verbally in pain," "admitted" that it was "possible that [SP2] swore out loud," and that his/her words were not intended to insult or harm the VA.

- At an unknown time towards the end of the EUMR, SP1 asked for the H and any community persons who were around the VA to "please go inside or give [the VA] some space" as the VA had a history of "attention seeking" behaviors, "increased" escalated incidents when in the community, and emotional dysregulation when "overstimulated." Shortly after the "crowd dispersed a bit," the VA "calmed," and the VA was released from the hold. About five minutes later, the VA walked with SP1 and SP2 to the facility's vehicle and they returned to the facility.
- SP1 and SP2 provided consistent information that EUMRs were only used to respond to the VA's physically aggressive behaviors after staff persons attempted to redirect the VA's behaviors and "de-escalate" the situation, the VA's behaviors were a safety risk to the VA and/or others, the VA was released from an EUMR as soon as it was safe to do so. The holds that staff persons used were consistent with the VA's care plans and the facility's policies which staff were trained on. SP1 and SP2 did not observe any injuries to the VA resulting from the incidents but noted that there were "minor" injuries to G1 and SP2.
- P1, P2, and P3 each stated that there were no similar concerns with SP1 or SP2 prior to this incident. Additionally, G1 did not observe any concerns with SP1's or SP2's interactions with the VA during the incident.

The MHP provided information that was consistent with the information provided above by SP1, P1, P2, P3, and G1. The MHP also provided the following additional information:

- The MHP did not have any concerns with the interactions between the VA and SP1 and SP2 during the appointment. Approximately 15 minutes after the VA's appointment ended, an unknown healthcare staff told the MHP about the situation outside and had concerns with how the VA was being restrained (later determined to be the actions of G1 during the second restraint). The MHP then went outside and saw SP1 and SP2 releasing the VA from an EUMR (third restraint) while G1 administered the VA's PRN.
- During the fourth/final restraint, the MHP was concerned with the "safety" of the restraint since it "appeared" that staff persons were "exhausted" and "almost falling into positions against [the VA's] movements and strength" resulting in the VA's arms being "momentarily" held at "awkward angles" that "appeared potentially painful." There were also "some moments" that "looked like" SP1 and SP2 "pinned [the VA] down" in a manner that the MHP stated was "rough" and "potentially restrictive" to the VA's airway. However, the MHP did not recall a time during the restraint that SP1 or SP2 applied any pressure to the VA's chest, neck, or face. The MHP had concerns with how SP2 responded to being bitten by the VA during this restraint and stated that SP2 "cried out," "Ouch, you dumb fuck. You bit me."

- The MHP was not aware of any injuries to the VA as a result of the restraints. The MHP also “thought” that SP1 and SP2 were “trying to do their best.” b
- Later that day and throughout the following week, the MHP contacted and had multiple follow-up conversations via phone with G1, P1, and P2 about the restraints, the observations made by the MHP and the unknown healthcare staff, concerns regarding the “safety” and “roughness” of the restraints, and the MHP’s recommendations to help “avoid” similar situations from occurring that included increasing the VA’s staffing to 3:1 while in the community and scheduling/conducting the VA’s future appointments with the MHP through telehealth services. During one call with P1, P1 asked the MHP if the facility could coordinate and schedule trainings with the MHP and clinic so that facility staff persons received the “same trainings” that the healthcare staff were provided and used for implementing “safer” and “more therapeutic” manual restraints. However, this was not an available option for the clinic to offer the facility at that time.

The CM stated that s/he was aware of the incidents and did not have any additional information to provide.

Regarding (202507591) incidents on August 19, 2025

The VA had a family member (FM) who resided at Facility 2, and the VA was visiting the FM when the incidents occurred. Facility 2 was a licensed residential program operated by a different license holder. Although the incidents occurred at Facility 2, the VA’s care was the responsibility of Fourth Avenue Homes and staff persons who worked there.

SP1, P1, P2, and P3; and the facility’s *Incident Reports* and *Behavioral Intervention Reporting Forms* provided the following information:

- On August 19, 2025, SP1 and SP3 worked at the facility during the dayshift with the VA. At approximately 12 p.m., G1 called the VA on his/her iPad using FaceTime and asked the VA if s/he wanted to go to Facility 2 to see the FM’s “newly emerged” butterfly but that G1 would not be there. The VA was “very excited” and turned his/her iPad towards staff persons to confirm that the VA could go since the activity was not planned/scheduled ahead of time which was an agreement among the VA’s care team. SP1 and SP3 “felt” G1’s request “put [them] on the spot” and were “hesitant” because of the VA’s history of aggressive behaviors but for the past seven days the VA had been doing “great” having no incidents of physical aggression, so they agreed. SP1 had not been to Facility 2 before but SP3 had and said there were prior incidents involving the VA when spending time with the FM including incidents that occurred at Facility 2 which made SP3 “worry” about “how the outing would go.”
- Around 12:10 p.m., SP1, SP3, and the VA arrived at Facility 2. The VA was “excited” to see the FM and his/her butterfly, however, the staff persons working “looked surprised” to see the VA and was not aware that the VA would be visiting. G1 had not contacted Facility 2 beforehand to schedule/communicate this with the FM. Due to prior incidents involving the VA and because the FM’s staff persons were not able to plan/prepare for the visit ahead of time, the VA was not able to see the FM which made the VA “very visibly upset.” The VA then walked around outside looking for another way in but the VA’s attempts to inside were not successful and the VA became “increasingly agitated.” SP1 and SP3 provided the VA with verbal prompts and redirection but the VA ignored them and “ran” to a neighboring home. The main entrance to the home had a front deck/landing area with a railing that enclosed the area with the exception of the steps.

- The VA was on the deck trying to enter the home but the door was locked so the VA started “banging” on the door while “repeatedly” ringing the doorbell trying to gain entry to the home. At approximately 12:18 p.m., as SP1 and SP3 tried to “de-escalate” the situation with verbal redirection, breathing exercises, and offering the VA’s “preferred” activities, the VA continued trying to get into the neighbor’s home and attempted to “hit” and “kick” SP1 and SP3 if staff persons approached the VA. SP3 then called P1 to notify him/her of the incident and P1 told SP3 that SP1 and SP3 needed to position themselves between the VA and the neighbor’s door so that the VA did not “kick in the door,” provide the VA with redirection, and to continue to encourage the VA to leave the area and “go back home.” P1 also told SP3 that they “might” need to restrain the VA if the VA did not stop his/her aggressive behavior. After the call with P1, SP1 and SP3 stood between the VA and the door which caused the VA to become “more agitated” and physically aggressive including trying to “hit, kick, and bite” staff persons.
- At approximately 12:31 p.m., while on the deck, SP1 and SP3 implemented an EUMR, “D Hold.” SP1 attempted to hold the VA’s left arm while SP3 straddled above the VA’s pelvic area and attempted to hold the VA’s right arm and “control” the VA’s leg movements. During the hold, the VA was “combative,” “screaming,” and attempted to “bite, hit, scratch, kick, and pinch” SP1 and SP3 while the FM and the Facility 2 staff persons watched from the driveway. After the VA stopped “screaming,” SP1 tried to talk to the VA providing “reassurance” telling the VA that s/he needed to be “calm” and “done” with the aggressive behaviors so that they could “let [the VA] up” and then the VA could go home to call G1. However, the VA remained “physically combative” towards SP1 and SP3 while pinching and scratching at their arms/hands and trying to kick and bite SP3.
- At some point during the hold, the FM started recording a video of the incident. Additionally, Facility 2 staff persons (which was later determined to include the S) “ran” to the neighbor’s front deck where SP1 and SP3 were restraining the VA. The S then told SP1 and SP3 that the “type of holds” they were using to restrain the VA were “hurting [the VA]” and “not allowed” in licensed programs, that the VA had “rights,” and that staff persons needed to “let [the VA] up.” SP1 then told the S that they were trained how to implement the EUMRs and that SP1 and SP3 were responding to the VA’s behaviors in a manner that was consistent with facility policies. SP1 said that maybe the Facility 2 staff persons were “maybe not trained like [SP1 and SP3]” but “at [the facility],” staff were “allowed to restrain [the VA] if [s/he] was in danger.” However, the S was “persistent” that the restraint was “illegal” and that the VA “could not breathe” which the VA then started to repeat. SP1 stated that s/he would “never” put pressure/weight on the VA’s chest or airways. SP1 and SP3 then released the VA and the VA “immediately” stood up, held onto the S, and “cried” to the S that s/he wanted to see G1. The restraint lasted approximately six minutes and then they walked back to Facility 2’s front yard with SP1 and SP3 following behind the VA and Facility 2 staff persons.
- “Almost immediately” thereafter, the VA asked the S if s/he could go inside Facility 2 but the S told the VA that s/he could not, which “upset” the VA “even more.” The VA then turned away from the S and started walking across the street towards another neighbor’s home while SP1 and SP3 followed behind. SP1 said that due to the VA’s history of entering homes and knowing the VA’s “triggers” were “frequently” followed by a “common pattern” of “unsafe” and aggressive behaviors, SP1 walked up to the VA from behind, took and held onto the VA’s arm, and attempted to verbally and physically redirect the VA away from the neighbor’s home towards the facility’s vehicle. The VA “immediately” turned around and tried to “scratch and hit” SP1. The VA, who was standing in the street, then “intentionally dropped” to the ground and tried to “grab” and bite SP1’s legs. The VA was able to grab landscaping rocks that were in the neighbor’s yard and began to throw the rocks at SP1 and SP3.

- At approximately 12:41 p.m., SP1 and SP3 placed the VA into another hold. "This time," SP3 attempted to hold the VA's left arm while SP1 straddled above the VA's pelvic area and attempted to hold the VA's right arm and "control" the VA's leg movements. The VA was "combative," "yelled and screamed," and engaged in physically aggressive behaviors towards SP1 and SP3 while Facility 2 staff persons watched again from across the street and told staff persons that LE had been called. The VA then started "yelling" that s/he wanted to go to hospital and was not going back to the facility until the VA could see G1. Approximately six minutes later, the VA stopped engaging in physical aggression towards SP1 and SP3 and was released from the hold. SP1 did not observe any visible injuries to the VA except "some minor blood" on his/her mouth that was "likely" caused from the VA biting his/her tongue during one of the incidents but did not need medical attention.
- Shortly after, the VA "agreed" to walk with staff persons to the facility's vehicle and got into the vehicle "on [his/her] own accord." As staff persons were also preparing to get in the vehicle, law enforcement officers (LEO) arrived. The VA then started "screaming and begging" for the LEO who were "familiar" with the VA and were aware of the VA's history, tendencies, care plans, and *Right Restrictions*. The LEO approached the facility's vehicle, talked to the VA through the window. The LEO talked with SP1 and SP3 and SP1 told the LEO what happened. The LEO then told SP1 and SP3 that it "looked like" they had "everything handled" to which SP1 and SP3 confirmed. The LEO then left and SP1, SP3, and the VA drove back to the facility.
- Once at the facility, SP1 and SP3 checked the VA for any injuries and saw that the VA had "some minor scrapes" on his/her elbows. SP1 also saw that the VA's mouth was no longer bleeding and there was not a visible injury to the VA's lips, tongue, or teeth. Facility documentation showed that both SP1 and SP3 each had "minor scratches," "scrapes," and "pinch marks" on their hands, arms, and knees.

P1 and P3 reviewed the video footage recorded by the FM on August 19, 2025, and noted the video as part of the *Internal Review*. This investigator's review of the video was consistent with the information provided in the *Internal Review*. The video was three minutes and forty-nine seconds long and did not show the beginning or the end of the EUMR. The *Internal Review* provided the following information:

[The video opened with] [The VA] voluntarily side-flipped into a prone position and remained there for approximately ten seconds without pressure being applied to [his/her] back. During this time, [SP3] maintained a straddled position above the VA but did not apply weight.

The VA then rolled into a supine position and began actively struggling, performing upward hip-bumping motions toward [SP3]. [SP3] repositioned [his/her] hips lower over the VA's pelvis and leg area to restrict movement and prevent further escalation.

At one point, [SP3's] right knee briefly contacted the VA's left arm for approximately three seconds with intermittent pressure while the VA continued to resist. Both staff [remained] calm [and provided] verbal communication throughout the incident to support de-escalation.

[SP1] placed [his/her] right hand on the VA's chin to prevent being bitten. Once the VA relaxed, [SP1] moved [his/her] hand to the VA's arm to maintain control. The VA turned [his/her] head toward [SP1], prompting [SP3] to place [his/her] hand on the VA's chin to

prevent another bite attempt.

As the VA continued hip-bumping, [SP3] stabilized with [his/her] right knee and left elbow, briefly contacting the VA's chest for approximately ten seconds. [SP3's] hands alternated between the VA's chest and chin area to maintain safety and balance. The VA attempted to bring [his/her] left arm inward; [SP3] repositioned it safely without applying pressure to the joints. [SP1] placed [his/her] right hand on the VA's left pectoral area to prevent rolling.

For approximately six seconds, [SP3's] left hand remained on the VA's upper chest as the VA continued resisting. When [SP1] began to lose control of the VA's right arm, [SP1] placed [his/her] left knee on the VA's right forearm for roughly fifteen seconds to regain control.

The video ended with staff maintaining control and ensuring safety. No excessive or unsafe pressure was observed.

The video was reviewed by [P3... who] determined that while the restraint deviated slightly from EMUR protocol, the circumstances were dynamic, beginning in the community setting and transitioning to a confined deck area with railings. Staff adapted to maintain safety as the VA displayed continued aggression, including biting attempts, hip-bumping, and rolling. The staffs' actions were reactive, not excessive, and aligned with their responsibility to protect the VA and others from harm.

[The facility's IR] confirmed ... that [SP1's and SP3's] actions were appropriate and consistent with maintaining control under high-stress conditions; minor deviations from the EMUR manual were situationally justified; [and] restraints were performed with professional communication, limited force, and situational awareness [while remaining] in compliance with [...the facility's policies].

The S provided information regarding his/her interactions with SP1 and SP3 that was consistent with the information each provided during their interview and/or in the *Internal Review*. The SP also provided the following additional information:

- It was "very, very hot" day with a "heat index that was over 100 degrees" and s/he asked a Facility 2 staff person to get the VA a drink of water and they did so. Shortly thereafter, the staff persons released the VA from the EUMR and the VA walked with the S back to Facility 2.
- The S believed that the second restraint that occurred across the street "seemed unnecessary [...] and excessive" because the VA "never even made it to the other neighbor's door" and the VA "only threw like two rocks." The S estimated that the incident lasted for approximately five to ten minutes and during that time, the FM was "visibly worried" about the VA and called 9-1-1 who arrived shortly thereafter. The VA was already in the facility's vehicle at that point. The LEO talked with the VA and the staff persons, with one of the responding law enforcement officers knowing the VA "very well." The S did not see any "significant" injuries on the VA and the LEO then determined that the VA was able to go back to the facility with SP1 and SP3.

The CM stated that s/he was aware of the incident and provided information that was consistent with SP1, P1, and facility documentation. SP3 worked with the VA for "several years" including at the VA's prior residential

setting that was not associated with the facility and the CM did not have any concerns with how SP3 treated or interacted with the VA. The CM reviewed the video footage and stated that it was “difficult” to “really see what was happening from that angle” in a “short clip” that did not show the “before or after.” The VA was “very strong” but the VA was also “significantly smaller” than both SP1 and SP3 and was able to “still move [his/her] legs, arms, and head, as well as free [him/herself] from the staff’s hold at times.” So even though it “may have appeared rough to onlookers,” “especially” to the FS who did not use any type of EUMRs in their programming, the staff persons were “probably not” applying the “excessive pressure or weight” as “perceived.” Additionally, the VA’s care team maintained “good communication” with LEO and updated LEO with the VA’s care plans and “relevant” information that was important for the LEOs to be aware of. There was a “recent” similar incident in which the VA “forcefully” entered a home in his/her neighborhood which “escalated” into a “physical altercation” between the VA and the neighbor and team was relieved that the neighbor did not press charges against the VA. Furthermore, when the LEO asked staff persons why they did not restrain the VA at an earlier time before it “escalated into an altercation,” staff told the LEO that they were “not allowed” to restrain the VA for property damage but “intervened” and placed the VA into a hold as soon as the VA was physically aggressive towards the neighbor.

G1 stated that s/he was aware of the incidents and did not have any additional information to provide regarding the allegation.

Law enforcement (LE) was notified and responded to the incidents but did not investigate further.

Relevant Rules and Statutes:

Minnesota Statutes, section 245D.061, subdivision 2, states that an emergency use of manual restraint must be used when immediate intervention is needed to protect the person or others from imminent risk of physical harm and the type of manual restraint must be the least restrictive intervention needed to eliminate the immediate risk of harm and effectively achieve safety.

Conclusion:

The VA’s plans showed that the VA had a history of physical aggression that required the use of EUMRs when the VA’s behaviors posed as an imminent risk of physical harm to the VA and/or others. The VA had a history of becoming emotionally dysregulated and engaging in maladaptive behaviors including physical aggression towards others, “especially” during/after spending time with family or when in the community; property destruction; “forcefully” entering homes of unknown community members; and “attention seeking” behaviors that included providing information to others about the VA’s health/safety that was “not always true” and “escalating” situations to a level where the VA thought G1 would respond to.

The VA also had “known triggers” including the VA becoming “upset” if a family member did not provide the VA with “instant attention” which then caused the VA to become dysregulated with escalating behaviors. Additionally, “all” community outings and/or visits with family members were to be scheduled with staff persons in advance so that it could be planned/communicated accordingly with the VA who was “most successful” when s/he was provided with consistent routines and adequate time to understand what was expected from him/her to participate in the planned activity. It was also important that staff persons had adequate time to make any necessary arrangements with others and/or to an environment prior to community outings that would help maintain the safety of the VA and the safety of others while allowing the VA to “successfully” interact within the community.

The VA's plans and the facility's *EUMR Policy* stated that staff persons were to use manual restraints if the VA's behaviors were an imminent risk of physical harm to the VA and/or to others until the VA was able to "return to [his/her] calm stage" while using the least restrictive intervention possible.

Staff persons' training included an understanding of the VA's behaviors, the VA's care plans, and the facility's *EUMR Policy*. P1, P2, P3 were each aware of the holds that staff used when implementing an EUMR and stated that the staff persons restrained the VA in a manner that maintained the safety of the VA/others and were consistent with the VA's care plans and facility policies.

*Regarding (202506386) incidents on July 17, 2025*

Due to the VA's history of maladaptive behaviors, the VA "usually" attended appointments with the MHP remotely through telehealth visits. However, the VA had an in-person appointment with the MHP on July 17, 2025, that was attended by the VA, G1, SP1, and SP2.

Information was consistent that during/after the VA's appointment, the VA became "anxious" and "agitated" and displayed escalated behaviors in a manner that that was consistent with the VA's "known" history and that were described in the VA's plans including physical aggression towards others. The VA's behaviors displayed in the MHP's office during the VA's appointment resulted in G1 and SP2 placing the VA in a manual restraint (first restraint) lasting approximately two minutes. The VA's behaviors displayed outside of the clinic after the VA's appointment resulted in SP1 and SP2 placing the VA in a manual restraint during three separate incidents with G1 assisting staff in restraining the VA during the second restraint, administering the VA's PRN during the third restraint, and leaving the area during the fourth/final restraint. The second restraint lasted approximately 14 minutes, the third restraint lasted approximately 4 minutes, and the fourth/final restraint lasted approximately 10 minutes.

The MHP stated that during the fourth/final restraint, SP1 and SP2 "appeared" to be "exhausted" while each attempted to maintain the EUMR against the VA's "strength" and behaviors resulting in the staff persons being positioned in ways that "momentarily" placed the VA's arms at "awkward angles" and that briefly "appeared" "rough," "potentially painful," and/or "potentially restrictive" to the VA. However, the MHP was not aware of any injuries to the VA as a result of the incident and did not recall a time during the restraint that SP1 or SP2 applied any pressure to the VA's chest, neck, or face.

Although the MHP had concerns regarding the manner in which SP1 and SP2 restrained the VA, given the VA's history of maladaptive behaviors and the VA's escalating physical aggression towards others at the time of the incidents, it was reasonable for SP1 and SP2 to intervene to maintain the safety of the VA and others including the use of an EUMR. In addition, the VA did not sustain an injury during the incident. Therefore, there was not a preponderance of the evidence whether SP1 and SP2 engaged in non-therapeutic conduct that could reasonably be expected to produce the VA physical pain or emotional distress.

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).

*Regarding SP2's response to being bitten on July 17, 2025*

Information obtained showed that when the VA bit SP2, SP2 "cried out" in response, using swear words. The MHP stated that SP2 said, "Ouch, you dumb fuck. You bit me." SP1 stated that SP2 "yelled out [...] aw, fuck" or "something like that" but did not recall SP2 "swearing" at or using "derogatory language" towards the VA.

SP2 did not provide information for this investigation but told P1 and P2 during the facility's internal review, that s/he did not recall "what exactly" s/he said but remembered "reacting verbally in pain." SP2 also said it was "possible" that s/he "swore out loud" but SP2's words were not intended to insult or harm the VA.

Although it was most likely that SP2 swore when the VA bit him/her, information was conflicting regarding whether it was a reaction or directed toward the VA. In addition, it was a single incident and consistent information was provided by the CM, SP1, P1, P2, and P3 that there were not any prior concerns with SP2's interactions with the VA prior to the incident. Therefore, there was a preponderance of the evidence that SP2's single use of swearing was not repeated and therefore would not reasonably be expected to produce 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 (202507591) incidents on August 19, 2025*

Consistent information showed that the VA "struggled" "most" in managing his/her emotions and behaviors when in the community and during/after spending time with family members which resulted in the VA's care team agreeing that such activities/visits were to be scheduled with the facility beforehand so that staff persons were able to make any necessary arrangements and adequately communicate plans in advance to help the VA "successfully" and safely interact within the community and/or with others.

Information was consistent from all sources that on August 19, 2025, G1 contacted the VA to ask if the VA wanted to go to Facility 2 to see the FM release his/her butterfly which was not planned in advance with the facility but SP1 and SP3 "agreed" to G1's request and transported the VA to Facility 2 shortly thereafter. However, this activity was also not planned/communicated with Facility 2 prior to the VA arriving which resulted in the VA not being allowed to enter. This "upset" and "agitated" the VA who then displayed escalated behaviors in a manner that was consistent with the VA's "known" history and that were described in the VA's plans including physical aggression towards others and attempting to "forcefully" enter the homes of unknown community members. The VA's behaviors displayed at neighboring homes of Facility 2 resulted in SP1 and SP3 placing the VA in a manual restraint during two separate incidents with each EUMR lasting approximately six minutes.

Although the S had concerns regarding the manner in which SP1 and SP3 restrained the VA, the FM recorded a portion of the first EUMR which showed that at different points during the restraint, SP1 and SP3 each attempted to maintain "control" against the VA's "resistance" resulting in the staff persons being positioned in ways that briefly applied pressure to the VA's chest multiple times and where staff persons were applying pressure to their knees, hands, and elbows to keep the VA restrained in a supine position without putting pressure on the VA. Each staff person also placed his/her hand on the VA's chin to prevent the VA from biting.

Given the VA's history of maladaptive behaviors, and the VA's escalating physical aggression towards others and trying to enter community persons homes at the time of the incident, it was reasonable for SP1 and SP3 to intervene to maintain the safety of the VA and others including the use of an EUMR. Therefore, there was not a preponderance of the evidence whether all of SP1's or SP3's conduct produced or could reasonably be expected to produce physical pain or injury or emotional distress to the VA.

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 internal reviews for the allegations and determined that the policies and procedures were adequate and were followed. Additionally, all staff persons were retrained on the facility's EUMR Policy.

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

No further action was taken.