DEPARTMENT OF HUMAN SERVICES

MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."

Report Number: 202510771

Date Issued: February 19, 2026

Name and Address of Facility Investigated:

REM Heartland Inc. - Eastwood
104 Cypress Court
Mankato, MN 56001

REM Heartland Inc.
6600 France Ave S suite 350
Minneapolis, MN 55435

Disposition: Substantiated as to neglect of a vulnerable adult (VA1) by a staff person and false as to physical abuse and neglect of another vulnerable adult (VA2).

License Number and Program Type:

1077059-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071456-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA1) left the facility during the night without a staff person's (SP) knowledge and walked to another residential program operated by the same license holder (facility B). Later that morning, another vulnerable adult (VA2) had injuries, including two black eyes.

Date of Incident(s): November 16, 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), 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 November 25, 2025; from documentation at the facility and law enforcement records; and through 12 interviews conducted with two supervisory staff persons (P1 and P2), six facility staff persons (P3-P7 and the SP), a staff person (P8) who worked at facility B, VA1's guardian (G3), and VA2's guardians (G1 and G2).

The facility had two levels with VA1's and VA2's bedrooms on the lower level and a living room on the upper level. Consistent information was provided that three staff persons worked during the day with VA1, VA2, and another client (C) and one awake overnight staff person.

Facility documentation showed that the SP and staff persons interviewed for this investigation were trained on VA1's and VA2's plans and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

Regarding VA1 leaving the facility during the night and walking to facility B:

VA1 was diagnosed with autism spectrum disorder. This investigator met VA1 but VA1 did not provide any information about the incidents. Consistent information was provided that VA1 enjoyed going to facility B once per week to play video games.

VA1's *ISSA Assessment Detail* stated that VA1 needed 24-hour staff persons supervision "at all times when in the community" because VA1 had limited communication skills and VA1 was not able to find his/her way back to the facility. VA1 did not look both ways when crossing streets and needed help with pedestrian safety skills. VA1 had a history of leaving the facility without supervision and running through yards, going into other persons' homes, or to other places in the community without regard to his/her safety. Staff persons provided transportation and accompanied VA1 while in the community.

VA1's *Risk Assessment Detail* stated that VA1 had a history of property destruction, including throwing objects. VA1 had a history of leaving the facility without supervision and alerts were installed on all exits and bedrooms windows that alerted staff persons by phone when the exits/windows were opened. If VA1 was in the main area of the facility, staff persons were to be in the same room as VA1 to intervene between VA1 and other clients if needed. If VA1 woke up during the night, staff persons provided assistance as needed. VA1 required 24 hour awake supervision. During the day, if staff persons needed to use the bathroom or assist another client, they communicated with other staff persons to transfer responsibility of VA1's supervision.
P8 provided the following information:

- On November 16, 2025, at approximately 2:30 a.m., P8 was working the overnight at facility B when s/he heard "banging" on the front door. P8 went to the door and unlocked it. When P8 opened the door, an unknown person (later identified as VA1) came inside. P8 had not met VA1 prior to this and VA1 went straight to playing video games. VA1 had on a long sleeve shirt, pants, and shoes but no jacket and did not appear injured. P8 stayed near VA1 while s/he called a supervisory staff person (P9) who then called P2.

- At some point, P2 and P3 arrived at facility B and interacted with VA1 until VA1 decided it was time to leave. At approximately 6:30 a.m., P2, P3, and VA1 left facility B.

According to googlemaps.com, the distance between the facility and facility B was 1.3 miles and was a 28-minute walk.

According to wunderground.com, on November 16, 2025, at approximately 2 a.m., the temperature in Mankato, MN was 34 degrees Fahrenheit.

P1-P3 and P7 provided the following information:

- On November 16, 2025, at approximately 2:35 a.m., P2 (who was not working at the time) woke up from a notification from the facility alert that the front door was opened. P2 texted the SP who was assigned to be working at the time, but the SP did not respond. At approximately 2:50 a.m., P2 was contacted by P9 who said that VA1 was at facility B. P2 got out of bed and drove to facility B. While driving, P2 tried to call the SP "numerous" times but the SP did not answer.

- When P2 arrived at facility B, VA1 was playing video games. At that time, VA1 did not want to leave so P2 called P3 who arrived at approximately 5 a.m. After P3 arrived, VA1 wanted to take a bath so P3 assisted VA1 with a bath while P2 left and went to the facility.

- At approximately 5:05 a.m., P2 arrived at the facility and when s/he went inside, the SP was "snuggled up" on the couch in the living room asleep. The SP "popped right up" and P2 asked the SP if s/he was aware that the overnight shift was an awake shift and the SP responded, "Yeah, but I was not sleeping." P2 asked the SP if s/he knew where all the clients were and the SP responded that they were all in bed. P2 then told the SP that VA1 was at facility B and the SP said, "I must have blacked out." P2 told the SP that s/he needed to keep the facility phone on him/her and P2 left and returned to facility B.

- At approximately 5:45 a.m. P2, P3, and VA1 left facility B and returned to the facility. At that time, the SP was awake in the kitchen and shortly after, P2 and P3 left the facility.

- P2 stated it was not typical for VA1 to wake up during the night unless s/he used the bathroom and typically s/he went right back to bed.

- P3 stated on an unknown date prior to the incident, the SP told P3 s/he was "experiencing" low iron and they discussed iron supplements and food that contained iron. The SP also said s/he "faint[ed]" or "black[ed] out visually" while at the facility. The SP did not provide P3 with any medical documentation and P3 told the SP to talk to P2 about it. P3 also told P2 about what the SP said. P2 said s/he was not aware of any medical conditions with the SP prior to the incident.

- P7 stated that on November 16, 2025, at approximately 8 or 9 a.m., s/he received a phone call from the SP who said s/he was "cooked." P7 asked, "Why?" and the SP said that earlier that night, s/he "stretched really hard," "passed out," and "hit" his/her head. When the SP "woke up" VA1 was not at the facility. P7 was not aware of the SP passing out prior to this.

The SP provided the following information:

- On November 16, 2025, at approximately 1 a.m., the SP began having health issues when on a personal call. The SP remembered being in the staff office, walking into the kitchen to drink some water, and "everything went black." The SP did not call any other staff persons during this time because his/her hands started going "numb."

- The SP could not remember his/her diagnosis but s/he had a condition where his/her heart did not beat correctly. This happened "many times" prior while the SP was working at the facility and the SP told P2 and P3 about it. The SP did not have medical documentation of his/her condition.

- When the SP "regained consciousness" P2 was asking where the clients were. The SP was confused and said they were all in their bedrooms and P2 said that VA1 had left the facility. The SP's heart continued "not beating right" and s/he was having "breathing problems." P2 left and eventually came back with VA1 and P3.

G3 had concerns that VA1 was allowed to leave the facility with an awake overnight staff person.

Regarding VA2's injuries:

VA2 was diagnosed with autism spectrum disorder with language impairment. Staff persons were at the facility "at all times" and VA2 had no unsupervised time at the facility. VA2's *ISSA Assessment Detail* stated that VA2 was not able to communicate if something was "wrong" but was able to communicate through his/her behavior. VA2 had a "high" pain tolerance and possibly needed medical attention even if s/he was not showing signs of pain.

VA2's *Risk Assessment Detail* stated that VA2 was vulnerable to physical abuse and communicated using minimal words and gestures. VA2 required frequent assistance and support with awareness, communication processing, judgment, memory, planning, problem solving, and perception. If staff persons observed VA2 in an abusive situation, they were to remove VA2 "immediately" and report any abuse to a supervisory staff person. Staff persons made an effort to inform VA2 of what abuse may look like and encouraged VA2 to communicate any form of abuse with staff persons.

G1 and G2 provided the following information:

- G1 stated that on November 16, 2025, at approximately 10:15 a.m., when G1 picked up VA2 from the facility, P2 told G1 that VA2 was injured when VA1 was throwing items. G1 then saw bruising around one of VA2's eyes. VA2's coat hood was up and blocked parts of his/her face. G2 stated that P2 called him/her and said that VA1 threw items that hit VA2 in the face and caused injuries.

- After arriving to G1's house, VA2 took his/her hood off and G1 saw bruising around VA2's whole left eye, bruising around the other eye, and multiple "gashes" on VA2's head some which appeared older. When

G1 asked VA2 what happened, VA2 responded, "Leave the fucking lights on." VA2 was echolalic (repetition of words or phrases spoken by someone else) so something possibly happened to VA2 during the night by a staff person. G1 and G2 each had concerns with the facility's ability to provide appropriate care to VA2.

P1-P7 and the SP provided the following information:

- On November 16, 2025, at approximately 5:45 a.m., VA1 returned from facility B (incident above) and went to his/her bedroom to go to sleep. At some point, the SP heard VA1 in his/her bedroom screaming and hitting something. The SP asked if everything was "okay" and VA1 responded, "Yeah, everything is fine." VA1 then came upstairs and started yelling and swearing so the SP contacted other staff persons. At this time, VA2 was standing in the living room.

- At approximately 8:10 a.m., P4 and P5 arrived at the facility because they were scheduled to work. P4 went to the living room where VA1, VA2, and the C were. P4 tried to calm VA1 but VA1 started throwing items around the room. P5 and the SP then brought VA2 and the C from the living room outside to the vehicle for their safety. At that time, P5 saw a cut on VA2's face but did not see any bruises. P4 and P5 each stated it was possible VA2 was hit with an item VA1 threw but neither saw VA2 get hit with anything.

- At approximately 8:20 a.m., P2, P3, and P6 arrived at the facility because of the notification and saw items thrown around the room and holes in the living room walls. VA1 was on the couch and eventually VA1 de-escalated and went to his/her bedroom. Staff persons then cleaned up the items that were thrown while P5 and the SP returned inside with VA2 and the C. At that time, P3 and the SP saw a bruise around the VA2's left eye and a scratch on his/her nose. The SP then left shortly after.

- That morning while P6 assisted VA2 getting dressed, P6 saw a bruise around VA2's left eye and a scratch on his/her nose and showed P2 the injuries. At that time, neither saw VA2's scalp. P2 then spoke to P4 and P5 about VA2's injuries and each said that when VA1 was throwing items around, something must have hit VA2.

- P2 called and notified G2 about the bruise around VA2's eye and the scratch and once G1 arrived at the facility, P2 told G1 about VA2's injuries. Later that day, G1 sent pictures of VA2 which showed that both of VA2's eyes were bruised and VA2 had multiple injuries on his/her scalp. P2-P7 and the SP each stated they were not aware of the injuries to VA2's scalp and did not know how VA2 received the injuries. The SP stated that s/he did not know how VA2 sustained the bruised eye and denied seeing scratches on VA2's face or head and/or doing anything to cause the injuries to VA2.

- On November 17, 2025, in the morning (prior to VA2 returning to the facility), P3 went into VA2's bedroom to clean and saw a towel in the corner of the room with blood, blood spots around VA2's bedroom, and two drops of blood in the stairwell. P3 told P2 about it.

- On November 18, 2025, P2 spoke with VA1 about staying safe. During the conversation, P2 asked VA1 if s/he had gone into VA2's bedroom before and VA1 responded, "Yes." VA1 then said s/he "hit" and "punched" VA2 in the nose, ear, and stomach. VA1 had a history of inaccurately providing information but P2 thought VA1 was truthful about hitting VA2 based on how s/he told P2 about the incident and VA2's injuries. Because of VA1's aggression towards VA2, P2 moved VA1's bedroom upstairs so staff

were able to provide more supervision at night.

- P2, P3, and P7 each stated that VA1 had a history of hitting but it was generally towards staff persons and not other clients. Staff persons did not have concerns with any other staff persons' interactions with VA2 or other clients.

Conclusion:

A. Maltreatment:

Regarding VA1 leaving the facility during the night and walking to facility B:

Consistent information was provided that on November 16, 2025, at approximately 2:30 a.m., VA1 left the facility without the SP's knowledge and walked 1.3 miles to facility B where P8 let VA1 inside and contacted supervisory staff persons. It was 34 degrees Fahrenheit outside and although VA1 was wearing a long sleeve shirt, pants, and shoes s/he had no coat or winter gear.

VA1 required 24-hour staff persons supervision "at all times when in the community" because of his/her limited communication skills and inability to find his/her way back to the facility. VA1 did not look both ways when crossing streets and needed help with pedestrian safety skills. VA1 had a history of leaving the facility without regard to his/her safety. VA1 required 24 hour awake supervision while at the facility. The facility had alerts on the front door and windows so if VA1 did leave the facility, staff persons were notified.

Although it was unknown when VA1 left the facility or how long s/he was unsupervised, given that VA1 required staff persons supervision at the facility and in the community and was able to leave the facility without the knowledge or supervision of staff persons; that VA1 was gone for an unknown amount of time but long enough to walk at least 1.3 miles before VA1 arrived to facility B and staff persons were notified (approximately two and a half hours from when VA1 likely left the facility to P2 notifying the SP); and that VA1 was exposed to dangerous situations and behaviors including not wearing proper clothing in 34 degrees Fahrenheit weather, there was a preponderance of the evidence that there was a failure to supply VA1 with reasonable and necessary care.

It was determined that neglect occurred (The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which 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).

Regarding VA2's injuries:

Information from all sources was consistent that on November 16, 2025, VA1 threw items around the living room where VA2 also was. When staff persons moved VA2 and the C into the vehicle, P5 saw a cut on VA2's forehead. Consistent information was provided by P2, P3, and P6 that once VA2 returned inside the facility, they noticed a bruise around VA2's left eye. Later, G1 noticed that both eyes had bruises around them.

Although no staff persons saw how VA2 sustained two black eyes, a scratch on his/her face, and injuries on his/her head, given that VA2 did not have injuries prior to the VA1 throwing things and was in the area with VA1 as VA1 threw things and that VA1 told P2 that s/he "hit" or "punched" VA2 in the nose, ear, and stomach, it was more likely that VA2 sustained the injuries as a result of VA1 and not staff persons actions. In addition, no one

had concerns regarding any staff persons interactions with VA2. Therefore, there was a preponderance of the evidence that staff persons did not cause VA2's injury.

It was determined that physical abuse did not occur (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).

In addition, consistent information was provided by P2, P3, and P7 that VA1 had a history of hitting but it was generally towards staff persons and not other clients. Given this, that once P2 found out about VA1 hitting VA2, VA1's bedroom upstairs was moved upstairs, and that information showed that staff persons intervened to protect the health and safety of VA2, there was a preponderance of the evidence that there was not a failure to supply VA2 with reasonable and necessary care.

It was determined that neglect did not occur (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).

B. Responsibility pursuant to Minnesota Statutes, section 626.556, subdivision 10e, paragraph (i):

When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

> (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;
>
> (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility's compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual's participation in the training, the caregiver's supervision, and facility staffing levels and the scope of the individual employee's authority and discretion; and
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> (3) whether the facility or individual followed professional standards in exercising professional judgment.

The SP was trained on VA1's plans and the Reporting of Maltreatment of Vulnerable Adults Act.

Although the SP stated that s/he had a medical condition, the SP was not able to provide information on his/her diagnosis or documentation of it. P3 stated that prior to the incident, the SP stated that s/he had previously passed out/fainted while working at the facility. Therefore, the SP had a responsibility to ensure his/her health did not impact clients safety while s/he was working. There was no information provided that the SP took any action related to his/her condition to ensure the safety of the clients when the SP was working. The SP was aware

s/he worked an awake overnight position and his/her possible medical condition did not mitigate his/her responsibility to ensure the safety and supervision of the clients including VA1.

The SP was the sole staff person at the facility and responsible for the safety and supervision of VA1. Therefore, the SP was responsible for the maltreatment of VA1.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

> "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated neglect for which the SP was responsible did not meet statutory criteria to be determined "serious" or "recurring" maltreatment because it was a single incident and VA1 did not sustain an injury that required the care of a physician.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed. VA1's bedroom was moved upstairs and two awake overnight staff persons were scheduled at the facility. VA1's and VA2's plans were updated to include the incidents and staff persons were provided training on the updated plans. The SP no longer worked at the facility.

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.