

**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: 202201794

Date Issued: May 13, 2022

Name and Address of Facility Investigated:

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

Rise Incorporated
8406 Sunset Rd. NE
Minneapolis, MN 55432

License Number and Program Type:

1069304-H_DSf (245D-Home and Community-Based Service-Day Services Facility
1069297-HCBS (Home and Community-Based Services)

Investigator(s):

Marci Sparrow
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

It was reported that after a staff person (SP) transported clients to the program, the SP did not check the van to ensure that all clients had exited. A vulnerable adult (VA) was left on the van for approximately one hour and twenty minutes unsupervised.

Date of Incident(s): March 7, 2022

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 17, paragraph (a):

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 March 25, 2022; from documentation at the facility; and through interviews conducted with two facility staff persons (P3 and the SP) and two facility management staff persons (P1 and P2). This investigator contacted the VA's family member (FM), who is also the VA's guardian, via phone and mail, but the FM did not respond. This investigator met the VA, but due to his/her diagnoses, s/he was unable to provide information.

Facility documentation showed that the VA was diagnosed with developmental disabilities and microcephaly. Documentation showed that the VA had limited verbal skills and communicated with a "shake of [his/her] head," or a "thumbs up or down." The VA's *Coordinated Service and Support Plan (CSSP)* showed that the VA had intervals of time up to 15 minutes of unsupervised time within the facility common areas, to use the bathroom, and while outdoors on the facility grounds. The VA did not have unsupervised time in the community. The VA's *Individual Abuse Prevention Plan (IAPP)* showed that the VA "lacked community orientation skills," was at risk in community as the VA was unable to seek out help if s/he was hurt or lost in the community, and was unable to be assertive or defend him/herself against abuse. The VA enjoyed being with his/her family members and playing with "fidgets."

The SP provided the following consistent information during his/her interview, to P1, and in facility documentation:

- On March 7, 2022, at 5 a.m., the SP left his/her house with the facility van and began the first part of the daily transportation route. The SP picked up eight clients on the route and transported them to the facility arriving at approximately 7:30 a.m. The SP assisted the eight clients from the van into the facility, then disinfected the van seats and visually checked for any clients that may have remained on the van. When the SP completed the check, at approximately 7:35 a.m. the SP left the facility to do the second half of his/her transportation route. The SP typically picked up eight clients, but on March 7, 2022, there were only seven clients because one client (C1) was going to be taken to the facility by his/her residential program after an appointment. The VA was the sixth client picked up that day at approximately 9:10 a.m.
- The SP then drove to the facility with the clients and arrived at approximately 9:45 a.m., approximately 15 minutes late due to traffic. The clients exited the van and the SP verbally cued the VA to get out of the van. The SP then got out, went to the back door to get a walker for a client (C2), and then walked to the side door and assisted C2 with the walker. As the SP assisted C2, C2 began "yelling" at the SP to put the walker together correctly. The SP then walked with C2 into the facility. The SP stated that s/he was not feeling well and after s/he assisted C2 into the facility, s/he went to the bathroom.
- Typically after assisting clients into the facility, the SP checked and disinfected the van, but on this date, because the SP was not feeling well, the SP wanted to drive to his/her house as soon as possible and decided that s/he would disinfect the van at home. During the drive to the SP's house, the SP did not see that the VA was still in the van. The van was a 15 passenger van with four rows of bench seats behind the driver. The seat backs were tall and had headrests. The VA sat in the third row (second to last) directly behind the SP, next to the window, and typically slept slumped over forward during transportation, so the SP did not see the VA in the van mirrors. At approximately 10:30 a.m., the SP arrived at his/her house and s/he immediately exited the van to get inside to use the bathroom. Because of this, the SP decided to disinfect the van after s/he used the bathroom. However, after the SP used the bathroom, s/he stayed

inside his/her house and did not go to the van but decided to disinfect the van prior to leaving his/her house around 12 p.m. to return to the facility to transport clients home.

- At approximately 11:50 a.m., the SP went outside to disinfect the van prior to leaving for the facility. The SP opened the side door of the van, stepped up into the van, and began to spray the disinfectant. As the SP moved to row three, the SP saw the VA sleeping slumped over forward in the seat. The VA appeared to be “sleepy” as if “waking up from a deep sleep.” The SP “gasp[ed]” and immediately asked the VA if s/he was “ok,” and the VA nodded his/her head, “Yes.” The SP asked the VA if s/he needed to use the bathroom or wanted a drink of water, and the VA shook his/her head, “No.” The SP stated that the VA was dressed in a heavy winter coat and was wearing gloves and a hat. The van was “still somewhat warm,” as the “sky was partly cloudy.” The SP then called P1 to report the incident and P1 directed the SP to drive the VA to the facility immediately.
- At approximately 12:30 p.m., the SP arrived at the facility with the VA. The SP walked with the VA from the van into the facility where the VA was met by P2 and then the SP went with P1 to explain the incident. The VA was calm, able to walk on his/her own, and showed no signs of distress or injury.
- The SP stated that s/he considered the incident “a perfect storm.” The VA had been on a two week vacation prior to the incident and it was the VA’s first day back from vacation, so the SP was “out of habit” of transporting the VA; C2 “yelling” at the SP about the walker, was “upsetting” to the SP; and the SP did not feel well. The VA was able to open the van door and exit without assistance, but the SP stated that s/he typically had to verbally remind the VA and C1 to exit the van more than once, or they would not get out of the van. Without seeing C1 seated in the van and the VA slumped over “sleeping,” the SP did not have the visual reminder to verbally cue the VA for a second time to exit the van as the SP assisted C2 with the walker.
- The SP stated s/he “felt horrible” about the incident and took “safety seriously every day.” The SP had never missed checking the van for clients after a route until that day. The SP stated that there was not an attendance sheet or process of checking clients on and off of the van. The SP typically checked each seat immediately after clients exited while the SP disinfected the van, and also did a “walk around” the van looking in all of the windows to ensure that nothing was missed.

P1, P2, and P3, and facility documentation provided the following information:

- P2 stated that on March 7, 2022, s/he was told by P1 that the SP called and said that the VA was left on the van for approximately one hour and twenty minutes. At approximately 12:30 p.m., the SP returned to the facility with the VA and P2 was at the front door waiting. P2 immediately walked with the VA to the bathroom to check the VA for any signs of distress or injury. P2 stated that the VA was dressed in a heavy winter coat, gloves, and a hat and as s/he checked the VA, the VA’s hands, head, ears, feet, and toes were all “body temperature” and showed no signs of redness. P2 asked the VA if s/he was “ok,” the VA nodded, “Yes.” P2 then asked if the VA was “hurt,” the VA shook his/her head, “No.” The VA then walked to his/her work station. The VA did not require any medical attention. P2 called the FM and informed him/her of the incident. The FM was “understanding” and agreed to let P2 know if any signs of injury or concern occurred after the VA returned home that evening.
- P3 stated that on March 7, 2022, the VA came to the work station at approximately 1 p.m. P3 documented the VA’s arrival on the attendance sheet and the VA sat at his/her work table. P3 did not notice anything unusual with the VA and/or the VA’s behavior, and thought s/he had just arrived late. P3 did not question that the VA’s late arrival because the VA was on vacation the two weeks prior so P3

thought the VA was not coming into work that day, or that the VA had an appointment before s/he came to work. P3 stated that s/he was not necessarily notified when clients were not coming to work or if they were going to be late. P3 did not know about the incident until the following day.

- P2 and P3 provided consistent information that the VA was a “quiet” individual and “slept a lot” while at his/her work table. The VA was “slow moving” and required a lot of verbal prompting to work or move onto the next activity. They each stated that although the VA knew how to open doors and exit vehicles, it was “unlikely” that the VA would have exited the van without a staff person’s verbal prompt.
- P1, P2, and P3, and facility documentation provided consistent information that the SP was an “excellent staff person.” The SP was “wonderful” with the clients and had several “special requests” from guardians and family members to have the SP transport “their loved one” to and from the facility. P1 stated that the SP was “one of the best” van drivers at the facility, and was reliable to complete all required safety checks and protocols. P1 stated that s/he was “shocked” that the incident occurred with the SP.

Website *Weather Underground* showed that on March 7, 2022, between 10:30 a.m. and 12 p.m., the temperature outside was between 18 and 22 degrees Fahrenheit, with 10 to 12 mile per hour (mph) wind, with 0 mph wind gusts, 0 precipitation, and “fair” for sun exposure.

The facility *Driver’s Manual* showed the last bullet under *Passenger Policies*, that “at the conclusion of each route, the driver MUST physically check all seats to assure all passengers have exited the vehicle by walking through the bus or van and checking every seat.”

Facility documentation showed that staff persons interviewed, including the SP, received training on Reporting of Maltreatment of Vulnerable Adults Act, the facility Driver’s Manual, and the VA’s plans prior to the incident.

Conclusion:

A. Maltreatment:

Information was consistent that on March 7, 2022, the VA was left unsupervised on the facility van outside the SP’s house for approximately one and a half hours.

Although the SP was not feeling well that day, given that it was a requirement of the SP to check the van for clients after each transportation route; that the SP had opportunities to check the van after using the bathroom at the facility, after arriving at his/her home, and after using the bathroom at his/her home, but did not do so; that although the VA was inside of the van out of the elements of the cold and dressed accordingly, the *Underground Weather* website showed that the temperatures were below freezing at 18 to 22 degrees Fahrenheit; and that although it was “unlikely” that the VA would exit the van without a staff person’s verbal prompt, the VA’s IAPP showed that the VA did not have unsupervised time in the community and that the VA “lacked community orientation skills,” and was at risk in community as the VA was unable to seek out help if s/he was hurt or lost in the community, there was a preponderance of the evidence that there was a failure to provide the VA with care or services that were reasonable and necessary to maintain the VA’s physical or mental health or safety.

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.)

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 responsible for the care and supervision of the VA at the time of the incident and was trained on Reporting of Maltreatment of Vulnerable Adults Act, the facility *Driver's Manual*, and the VA's plan. The SP was responsible for maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services. Minnesota Statutes, section 245C.02, subdivision 16, states:

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

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

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

It was determined that the substantiated neglect for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious as it was a single incident of maltreatment and the VA did not require the care of a physician.

Action Taken by Facility:

The facility completed an internal review and determined that policy and procedures were adequate, but not followed as the SP did not check the van after the transportation route was completed. The SP was retrained on the Reporting of Maltreatment of Vulnerable Adults Act and the facility Driver's Manual.

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.