

**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:** 202205196

**Date Issued:** September 30, 2022

**Name and Address of Facility Investigated:**

**Disposition:** Substantiated as to emotional abuse of a vulnerable adult by a staff person.

Community Living Options-Dellwood  
49 Dellwood Cove  
Dellwood, MN 55110

Community Living Options  
26022 Main St.  
Zimmerman, MN 55398

**License Number and Program Type:**

1070502-H\_CRS (Home and Community-Based Services-Community Residential Setting)  
1070470-HCBS (Home and Community-Based Services)

**Investigator(s):**

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Licensing Division  
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**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) threatened a vulnerable adult (VA) and chased the VA with a knife.

**Date of Incident(s):** June 25, 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 2, paragraph (b), clause (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: 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 July 13, 2022; from documentation at the facility, law enforcement records; and through five interviews conducted with one facility staff person (P), the vulnerable adult (VA), the VA's case manager (CM), an administrator with the VA's employment service (AP), and the VA's housemate (HM).

This investigator tried to contact the SP through various means; email, telephone, and mail, to set up an interview. Those attempts were unsuccessful.

The VA's diagnoses included bipolar disorder, oppositional defiance disorder, and psych-stressors. The VA enjoyed spending time with family, playing, and watching basketball.

The facility was located off of a private road about one-tenth of a mile from the main road. On the main level there was a living room, kitchen, a medication (med) room, and three bedrooms. The lower level had a bedroom, family room, and an office for staff.

The VA provided the following information:

- The VA stated that s/he, the HM, and the SP were in the kitchen when the HM made a "simple, harmless" joke about a t-shirt that the SP was wearing. The VA said it escalated from there. The VA asked the SP to calm down, that there was no reason to be rude. The VA told the SP not to disrespect the house where the VA and the HM lived.
- The SP got close to the VA to where their noses touched. The VA told the SP to back up and pushed the SP away. The SP got "mad." The VA told the SP to get out of the house.
- The SP went outside and the VA and the HM tried to calm each other down. The HM went to his/her room.
- The VA went outside to have a cigarette. The SP passed the VA, went back into the house, and came back outside with a knife. The SP told the VA, s/he was "going to cut your throat and gut you like a pig." The VA described the knife as having a brown handle with a pointy end "like the kind at Chipotle, to cut stuff up."
- The VA pulled out his/her telephone and called 9-1-1. The SP started to chase the VA. The 9-1-1 dispatcher told the VA to go to the end of the driveway and flag down the officers.

Law enforcement records provided the following information:

- When a law enforcement officer (LEO1) arrived on the scene, the VA waived LEO1 down at the end of the driveway. LEO1 asked the VA what happened and the VA said the SP threatened him/her with a knife. LEO1 drove the VA back to the facility in the backseat of the squad vehicle.

- LEO1 spoke with the SP. The SP told LEO1, s/he and the VA got into an argument about food, which led to the VA walking out of the house saying "come outside motherfucker." The SP stated s/he grabbed a butter knife and went outside to confront the VA at which point the VA ran away.
- LEO1 informed a law enforcement officer (LEO2) that they would be arresting the SP when LEO2 arrived on site. LEO1 and LEO2 approached the SP and told him/her that they were placing him/her under arrest. The SP complied, was handcuffed, and was escorted to a squad vehicle.
- LEO1 spoke with the VA and the HM, who provided consistent information as to what led to the argument and how it escalated.
- The SP told LEO1 that s/he returned the butter knife to the kitchen drawer. At that time the P arrived on scene and told LEO1 that sharp knives were locked away. All of the sharp knives were accounted for.
- LEO1 read the SP his/her rights and the SP told LEO1 that s/he wanted to speak with LEO1. The SP told LEO1 that s/he grabbed a butter knife when the VA told the SP to come outside. The SP told the VA "I'll chop you bitch ass up with this butter knife."

The P and the facility's records provided the following information:

- The P received telephone calls from both the HM and the SP. The HM told the P that the SP was "going off." The P told the HM and the SP that s/he was on his/her way to the facility.
- According to the *Internal Review*, the P received a telephone call from the SP asking the P to call the SP an Uber before s/he "beats [the VA's] ass." The P told the SP to calm down and go into the med room.
- In the facility's *Incident Report*, the P said that LEO1 and LEO2 found a bottle of liquor in the SP's backpack before they left with the SP. On a prior occasion, the VA stated that the SP showed up to the facility with liquor on the SP's breath. There was no mention of the SP "smelling" like alcohol or a bottle of liquor in the *Law Enforcement Report*.
- The P said the VA could "stretch a story out."

The CM stated that the VA can "fabricate" things, but there was something that happened with the SP.

The AP said the broad stroke of what the VA's says is true, but the details are "exaggerated."

The HM said the whole thing started because of a joke s/he made to the SP about a t-shirt the SP was wearing. The SP started "yelling and ranting." The VA told the HM to go to his/her room in case s/he needed to call the police.

Facility records showed that the SP was trained on the Reporting of Maltreatment of Vulnerable Adults and the VA's plans.

Law enforcement records showed the SP was cited and charged with two misdemeanors, Assault-5<sup>th</sup> degree and Possession of a dangerous weapon.

**Conclusion:**

**A. Maltreatment:**

The SP, the VA, and the HM were in the kitchen when the HM made a joke about the t-shirt the SP was wearing. The SP started "yelling and ranting," so the VA told the SP to calm down. The SP and the VA were nose to nose and the VA told the SP to get out of the house. As the VA was going outside for a cigarette, the SP came back into the house, grabbed a knife, went back outside, threatened the VA, and chased the VA with the knife.

The VA called 9-1-1 and when LEO1 arrived on the scene, the SP stated s/he grabbed a butter knife when the VA said to "come outside motherfucker." LEO1 and LEO2 placed the SP under arrest at which point, the SP told LEO1 that s/he told the VA "I'll chop you bitch ass up with this butter knife," when s/he argued with the VA.

While there was a discrepancy between the VA and the SP about the type of knife used and why the argument started, there was a preponderance of the evidence the SP threatened to harm the VA while holding a knife.

It was determined that 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).

**B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):**

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

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

The SP was trained on the Reporting of Maltreatment of Vulnerable Adults and the VA's plans. The SP stated s/he

threatened the VA with a knife. 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 emotional abuse for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious because it was a single incident that did not meet the definition of serious.

**Action Taken by Facility:**

The facility completed an *Internal Review* and found their policies and procedures adequate. The SP no longer worked for 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.