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: 202301402

Date Issued: May 26, 2023

Name and Address of Facility Investigated:

River Hills Home Health Inc.
4020 Minnehaha Ave
Minneapolis, MN 55406

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

License Number and Program Type:

1090530-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) staff person inappropriately touched a vulnerable adult (VA) while s/he was asleep.

Date of Incident(s): February 13, 2023

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 (c):

Any sexual contact or penetration between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility. Sexual contact is defined by Minnesota Statutes, section 609.341, as the intentional touching of the intimate parts with sexual or aggressive intent. 'Intimate parts' includes the primary genital area, groin, inner thigh, buttocks, and breast.

Summary of Findings:

Pertinent information for this investigation was obtained remotely, including documentation from the facility, law enforcement records; and through four interviews conducted with the vulnerable adult (VA), the VA's case manager (CM), and two supervisory staff persons (P1 and P2). Attempts were made via phone and mail to contact and interview a staff person (P3) who worked with the VA's roommate, but P3 did not respond to the requests or requests made by law enforcement.

The staff person (SP) was reached via telephone for an interview and said s/he would call back but did not. Letters requesting an interview were then mailed to the SP. The SP called and a telephone interview was scheduled with the SP, but the SP did not answer at the scheduled time. The SP responded three days later and said s/he wanted to talk with his/her attorney prior to interviewing. During the scheduled follow up phone call with the SP, s/he had not yet spoken to his/her attorney. A subsequent voicemail was left but the SP did not respond.

The SP was interviewed by a Law Enforcement Officer (LEO) and that information was included below.

The VA was physically disabled and required assistance with hygiene and using the toilet. The VA graduated with a degree in social work, volunteered with a non-profit, and was a strong writer.

The VA received eight hours a night of night supervision services at the time of the incident.

The VA provided the following consistent information during his/her interview and to the LEO:

- The SP previously worked with the VA's roommate and worked with the VA for a few months. The SP was "really rough" with cares when s/he assisted the VA after the VA used the toilet. The SP said it was to the point where it was "painful" for the VA's "genitalia." The SP told the VA it was to prevent medical issues. The VA did not inform the service provider of his/her concerns with how the VA performed these tasks.

- On February 13, 2023, in the early morning hours, around 1 or 2 a.m., the VA used the toilet. The VA said afterwards the SP was again "really, really rough" with the VA's cares and s/he asked the SP to stop. The VA returned to his/her bed, experienced leg muscle spasm pain, and so s/he asked the SP for a massage. The SP massaged the VA's leg and the VA started to fall asleep. The VA believed the SP thought s/he was asleep and the SP started to massage other areas of the VA's body. The VA asked what the SP was doing and pretended to fall asleep. For the next hour, the SP massaged and touched the VA's body including the VA's chest and genitals both on and under his/her clothing. The VA was awake the entire time, but pretended to be asleep.

- After the massage, the SP lay his/her head on the VA's chest and the SP "pretended" to be asleep. The VA opened his/her eyes and asked the SP what s/he was doing, but the SP did not respond. The VA saw that the SP appeared to be "like a deer caught in headlights." The VA asked the SP to leave the bedroom which s/he did. The VA then lay in bed awake until around 5:30 a.m.

- At 5:30am the SP returned to the VA's bedroom and asked to talk. The VA said s/he was aware of what the SP did, that it was sexual assault, and the SP needed to leave. The SP asked the VA to "forgive" the SP several times and the VA again told the SP to leave. The SP then left the bedroom. The VA was unsure if the SP remained in the home during this time.

- The VA called out for his/her roommate who came into the bedroom. The VA told his/her roommate about what the SP had done and asked if the SP was still in the home. The roommate confirmed that the SP was still in the home, then the SP left the home about 30 minutes later.

- About 7:30 a.m., the VA received a call from the SP's supervisor (P4) who said the SP told P4 what happened and that the SP no longer worked for the company. The VA then got a call from P1 to discuss what occurred and told the VA that the SP no longer worked for the company. Around 10 a.m. the VA called law enforcement.

- The VA said s/he was "scare[d]" the SP would continue to work with other vulnerable adults, especially non-verbal individuals. The VA was concerned the SP could do this again to someone else who was not able to or would not report it.

P1 provided the following consistent information during his/her interview and to the LEO:

- On February 13, 2023, around noon, P1 received a phone call from P4 who told P1 that the SP sexually assaulted the VA. P1 spoke to the VA on the phone and then drove to the VA's home, met with him/her, and discussed what had occurred.

- The VA told P1 that the SP arrived to work about 11 p.m. and about midnight, the VA used the toilet and asked the SP to assist him/her back to the bed. About five minutes later, the VA experienced leg spasms and asked the SP for a 10 milligram THC CBD gummy which s/he took regularly for pain. The VA took the gummy and denied to P1 that it impaired his/her judgement. Due to muscle spasms, the VA asked the SP to massage his/her outer right leg about a hand's length above the knee which the VA regularly got massages from staff persons due to pain.

- The VA said the SP massaged the VA's leg and moved his/her hands down to the VA's foot. The SP slid his/her hands back up the VA's sides and to the VA's chest. The VA asked what the SP was doing and then pretended to be asleep. The VA's cellphone normally was kept on his/her chest, but that night it was on a table and not within his/her reach. The VA was in a "freeze response," was not sure what to do or say, and continued to pretend to sleep and snore. For about an hour, the SP continued to massage the VA's chest and genitals on and under the VA's clothes. The SP then put his/her head on the VA's chest and fell asleep for a few minutes.

- The VA told P1 that about 2:30 a.m., s/he gasped for air causing the SP to wake up. The SP then "jumped up" and gave the VA a "blank stare." The VA asked what the SP what s/he was doing, the SP got up, and "had a shocking look on [his/her] face." The SP said s/he fell asleep. The VA told the SP to leave the bedroom and the SP did.

- At 5:30 a.m., the SP came back into the VA's bedroom and asked for "forgiveness" several times. The VA said, "No," and told the SP to leave the bedroom, and the SP left. The VA then called out for his/her roommate, but the SP returned and the VA told him/her again to leave. The roommate came into the bedroom and gave the VA his/her phone.

- The VA told P1 about how angry s/he was at the SP, how hard it was for him/her to sleep, and that s/he felt dirty. Later after the VA spoke to the LEO, P1 asked if the VA wanted to shower and the VA became tearful because no one asked him/her this yet. P1 assisted the VA in the shower.

- That day, P1 attempted several times to get ahold of the SP by text and telephone. At 3:30 p.m., P1 spoke with the SP by phone. The SP said s/he arrived to work with the VA at 10 p.m. the previous night. The SP helped the VA to and from the bathroom and into bed. The VA experienced leg muscle spasm pain and the SP gave him/her a CBD gummy. The VA asked the SP to massage his/her body to help with the pain. The SP thought the VA was awake and then went to sleep. The SP said, "I proceeded to massage [the VA] where I shouldn't," touching the VA's chest, "backside," and "a little bit of a massage in [the VA's] private area." The SP said s/he "got carried away" during the massage.

- The SP then lay his/her head the VA's shoulder and the VA asked him/her to leave. The SP left the bedroom and returned about 5:30 a.m. The SP asked if the VA needed assistance to get into his/her chair and was told, "No," and the VA asked the SP to leave the bedroom. The SP apologized to the VA for what occurred and that s/he "knew it was out of order I was really sorry for my actions."

- P1 provided a voicemail from the SP where s/he requested to have paperwork clarified that his/her intent was to massage the VA. The VA said in the voicemail to P1, "You start out with a sexual statement [in the *Corrective Action* form], that was the end result of a situation, not the intent or started the situation."

P2 provided the following information:

- On February 13, 2023, at 8 a.m., P2 received a call from the VA's roommate and P3 who told P2 that P3 heard the VA "yelling" at the SP. P3 went to see what happened and heard something along the lines of the VA scream at the SP get out of the house. P3 also told the VA to leave the house.

- The VA told his/her roommate and P3 that the SP was rough when s/he helped the VA with toileting, and assisted the VA to bed. The VA asked for a leg massage and pretended to sleep while the SP massaged his/her leg. The SP continued to massage the VA's leg and then touched the VA's chest and genitals for the next hour while the VA pretended to sleep.

- The VA said s/he confronted the SP and asked him/her to leave. The SP asked for forgiveness and the VA yelled at the SP. This alerted the roommate and P3 who came to the VA's bedroom and the SP left. P3 phoned the SP who admitted to what s/he did. Around 8 a.m. the VA's roommate phoned P2 about the situation.

- P2 attempted to contact the VA to encourage him/her to call the police, but did not hear back. (Note: The VA phoned the police, time unknown, and officers arrived at the home about 10 a.m.) P2 contacted the VA's CM about the situation.

- P2 was not aware of any similar concerns about the SP's behaviors from other clients and believed they would have reported any inappropriateness.

- The CM stated that on February 13, 2023, at 11:14 a.m., the VA and P1 called the CM. The VA provided information to the CM that was consistent with the information the VA provided this investigator and the LEO.

The LEO report provided the following additional information:

- On February 13, 2023, the VA's roommate heard him/her yell for the roommate. The roommate found the VA "in shock and was having a panic attack."

- At 7:28 a.m., the SP phoned his/her immediate supervisor and said there was an incident with the victim that was sexual and inappropriate. The SP said s/he gave the VA a massage and "I got carried away."

- The SP's supervisor said s/he was told by the VA that at 5:30 a.m. when s/he called out for the roommate, the roommate's staff person told the SP the VA was in need. When the roommate, the roommate's staff, and the SP were in the VA's bedroom the VA told them what the SP had done. The SP then left the home.

- At 9:54 a.m. the SP sent his/her supervisor a text where s/he apologized.

- On February 14, 2023, LEO spoke with the SP. The SP said s/he worked with the VA for about one and a half months. On February 13, 2023, around midnight the SP worked with the VA and the VA asked for a massage due to muscle spasms. The SP said that while massaging the VA, s/he "got carried away" and touched the VA's chest under and on his/her clothes. The SP touched the VA's buttocks and genitals over his/her clothing. The incident lasted about 45 minutes and the SP put his/her head on the VA's chest and fell asleep. The SP said the VA was both aware and asleep during the incident. The VA told the SP to leave. The SP apologized, said it was inappropriate and out of order, and asked for forgiveness. The VA told the SP to leave, and s/he left. The LEO submitted the report to the County Attorney for charges against the SP for non-consensual sex contact 5th degree criminal sexual fondling.

Facility documentation showed that the SP was trained on the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

A. Maltreatment:

The VA provided consistent information during his/her interview, to the LEO, to P1, and the CM that on February 13, 2023, in the early morning hours the VA asked the SP for a leg massage due to muscle spasms. The SP massaged the VA's leg and began to massage other body parts of the VA's including his/her chest, backside, and genitals.

The SP told the LEO and P1 that s/he touched the VA's chest, buttocks, and genitals; and that s/he "got carried away and asked the VA for forgiveness.

Given the consistent information provided by the VA and the SP regarding the incident, there was a preponderance of the evidence that the SP had sexual contact with the VA.

It was determined that sexual abuse occurred (any sexual contact or penetration between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility. Sexual contact is defined by Minnesota Statutes, section 609.341, as the intentional touching of the intimate parts with sexual or aggressive intent. 'Intimate parts' includes the primary genital area, groin, inner thigh, buttocks, and breast).

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:
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> (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;
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> (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
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> (3) whether the facility or individual followed professional standards in exercising professional judgment.

Facility documentation showed that the SP was trained on the Reporting of Maltreatment of Vulnerable Adults Act.

The SP was responsible for maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

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

Minnesota Statutes, section 245C.02, subdivision 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 sexual abuse for which the SP was responsible was not recurring because it was a single incident, but it was serious maltreatment because the SP sexually abused the VA.

The SP was disqualified from providing direct contact services.

Action Taken by Facility:

The facility completed an internal review, and determined that policies and procedures were adequate, but not followed. The SP no longer worked at the facility.

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

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