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: 202304400

Date Issued: August 30, 2023

Name and Address of Facility Investigated:

Pathway House
613 2nd Street Southwest
Rochester, MN 55902

Disposition: Inconclusive

License Number and Program Type:

802845-SUD (Substance Use Disorder)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) showed a vulnerable adult (VA) his/her genital area, touched the VA's buttocks, and "hit on" the VA.

Date of Incident(s): Unknown prior to December 12, 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 (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 was obtained during a site visit conducted on January 31, 2023; from documentation at the facility; and through four interviews conducted with the VA, two facility supervisory staff persons (P1 and P2), and the SP. Attempts were made via phone and U.S. mail to contact and interview the VA for follow up information, but the attempts were not successful.

The VA began receiving services from the facility on September 5, 2022, and graduated on December 12, 2022. The VA received treatment services for cannabis use disorder and stimulant related disorders. The VA was diagnosed with attention deficit hyperactivity disorder, anxiety disorder, and dissociative identity disorder. The VA worked at a local orchard where the SP also worked (Note: It was unknown when the VA began working at the orchard). The VA enjoyed spending time with friends and family and going on walks.

The VA's *Individual Abuse Prevention Plan* did not identify any susceptibility in the areas of sexual abuse.

The VA said that on an unknown date, the SP showed the VA his/her genital area, touched the VA's buttocks, and was "hitting" on the VA. The VA said that these things occurred in his/her bedroom at the facility.

P1 provided the following information:

- The SP worked at the facility three days a week (Monday, Wednesday, and Friday) as a "carpenter" and cleaner and would shop. P1 also said that the SP was "on call" and at the facility when needed but the SP did not interact with the clients and was never unsupervised with them, including in their bedrooms. The SP may be in a client's bedroom to fix or clean something but not when the clients were present. The SP also worked at a nearby apple orchard where the VA also worked.

- The SP had worked at the facility for approximately three years and P1 did not have any concerns with the SP's interactions with the clients.

- P1 was not aware of the SP touching clients on their buttocks or showing them his/her genital area, including with the VA. P1 was not aware of the SP hitting on a client.

- P1 did not know if the VA was an "honest person." However, P1 was not aware of any concerns between the VA and the SP.

P2 provided the following information:

- The SP fixed things, went shopping, and did "random things." The SP was typically at the facility "every week" but more so during the winter because the SP worked at an orchard full time in the summer so was not at the facility "as much." There was "usually always" someone nearby when the SP was present. The SP did not have much "client contact" and typically only saw the clients when s/he was outside smoking. The SP would only be in a client's bedroom if the SP was fixing something or cleaning out a room and during these times, the clients were in group.

- A "handful" of clients, including the VA, worked with the SP at the orchard which was unrelated to the facility and separate employment for the SP.

- P2 did not have any concerns with the SP's interactions with the clients. P2 described the SP as "nice, respectful, [and] quiet." P2 was not aware of any staff persons or clients having concerns with the SP's interactions.

- P2 was not aware of the SP showing any client his/her genital area. P2 was not aware of the SP hitting on a client but said that the SP could "make a joke." P2 was not aware of the SP touching a client, including the VA, on his/her buttocks. P2 did not think the concerns happened at the facility but "did not know what went on at the orchard." P2 did not know what kind of "relationship" the VA and the SP had while at the apple orchard.

- The SP was not at the facility "much" when the VA was at the facility. However, at some point, the VA was moving out a TV stand and the SP helped the VA with that. The VA was "mad" during this because the VA had put the TV stand in a nearby dumpster but was asked by the facility to remove it.

- P2 thought facility staff persons would have heard about the incident if it happened as it would have been a "big deal." The VA also had a history of "stirring the pot" and saying things that "may or may not be true."

The *Internal Investigation of Suspected Abuse, Neglect, or Maltreatment of a Vulnerable Adult* provided the following information:

- There was no specific time or date provided as to when the incident occurred, aside from sometime during the three months that the VA received services at the facility. The SP typically did not work at the facility during the warmer months due to working full time at the orchard. During the time that the VA was at the facility, the SP did not begin working at the facility until December 1, 2022. The SP then worked "as needed" during the winter for "projects" at the facility.

- There were only two dates where the VA and the SP would have seen each other at the facility (December 9 and 12, 2022). The two days that they would have been together, the SP was with another staff person and all of the clinical and non-clinical staff were also working. During these times, the SP was installing security cameras at another location operated by the license holder and was not often at the facility the VA received services except to eat lunch with the other staff persons.

- The SP said that s/he met the VA prior to the VA being a client at the facility because they worked at the orchard. The SP said that s/he could only think of one time that s/he had seen the VA at the facility and that was when the VA was in the facility parking lot bringing something to the dumpster. The SP denied having any direct or unsupervised contact with the VA. The SP denied seeing the VA in his/her room and denied making any sexual comments or actions towards the VA at the facility or any other time. The SP said there was one time at the orchard which may have "stemmed from this report" and this was during the time that the SP was at the orchard urinating outside. The VA come outside and saw the SP urinating. The VA looked at the SP's genital area and the SP asked the VA in a joking manner, "Did you get a good look?" There were no other times that the VA saw the SP's genital area.

- The SP denied touching the VA's buttocks. The SP denied making "any moves" towards the VA or "hitting" on the VA.

The SP provided the following information:

- The SP cleaned client rooms and did other maintenance at the facility. However, the clients were not in their rooms during the times the SP did this and said that the clients were typically in group or working. The SP also worked full time at an orchard so did not always work at the facility during those months s/he was at the orchard.

- The SP first met the VA at the orchard because they both worked there. At some point after, the SP became aware that the VA was also a client at the facility. However, the SP did not recall seeing the VA while at the facility and tried to "avoid" the VA because the SP "could not stand" the VA after having worked together at the orchard.

- In approximately October 2022, prior to the SP returning to work at the facility from working full time at the orchard and prior to the SP becoming aware that the VA was a client at the facility, around 8 p.m., the SP and the VA were at the orchard and a "few" of the SP's friends/co-workers were having "drinks" in the "workshop." During this time, the VA was working on fixing a vehicle nearby. The SP then went outside to urinate and during this time, the VA began "walking in front of [the SP]." The SP said to the VA, "What the hell?" and then once the SP was done urinating, the SP walked inside. The SP thought that the VA must have gotten a "good look" at his/her genital area because the SP "did not quit peeing" when the VA was present.

- Additionally, at some point, the SP tried to "fire" the VA from the orchard because at times, the VA and the SP "got into it." This included that the VA "crossed boundaries" and tried to make sexual "jokes" with the SP. The VA also tried to "rub" his/her body against the SP. The VA also tried to fix a golf cart in the middle of a field which s/he was not supposed to do. The VA did not end up getting fired and was "mad" at the SP after that.

- The SP denied touching any client's buttocks, including the VA's. The SP never "hit" on the VA and said that s/he did not have contact with the VA after s/he tried to get the VA fired from the orchard, which was prior to the VA becoming a client at the facility.

The *Employee Code of Ethics* said that all employees were to maintain the highest degree of professionalism both at and away from the facility. The facility "personnel and volunteers" were not to exploit clients sexually. The "personnel" were prohibited from engaging in sexual contact with clients during treatment or for a period of two years following treatment. Staff persons were to maintain appropriate boundaries with the clients.

The *Client's Rights and Responsibilities* said that clients had the right to be free from abuse. A "provider" was not to engage in any sexual behavior with a client, including anything that could be reasonably interpreted to be "sexually seductive."

Facility documentation showed that the SP, P1, and P2 received training on the facility policies and procedures, including the employee code of ethics and the Reporting of Maltreatment of Vulnerable Adults Act. The SP and P1 were also trained on ethical boundaries and the abuse prevention plan.

Conclusion:

The VA received services from the facility between September 5 and December 12, 2022. The VA said that on an unknown date, the SP showed the VA his/her genital area, touched the VA's buttocks, and was "hitting" on the VA. The VA said that these things occurred in his/her bedroom at the facility.

P1 and P2 said that the SP was never unsupervised with the clients and were not aware of any concerns between the VA and the SP, including the SP touching the VA inappropriately. P1 and P2 did not have any concerns with the SP. Information from the facility also showed that there were only two dates that the VA and the SP were at the facility together.

Although P1 was not aware of any concerns between the VA and the SP, the SP said that s/he had worked with the VA at the apple orchard and that there were interpersonal concerns, including that the VA was "mad" at the SP for the trying to get the VA fired at the orchard.

The SP provided consistent information to this investigator and in the internal review that while working at the apple orchard (which was separate employment than the facility), the SP urinated outside and the VA saw this. The SP thought that the VA must have gotten a "good look" at his/her genital area as the SP "did not quit peeing" when the VA was present. There were no other times that the VA saw the SP's genital area. The SP also denied being alone with the VA at the facility, including in the VA's bedroom. The SP also denied touching the VA's buttocks or "hitting on" the VA.

Without witnesses or any other information to corroborate the VA's descriptions of the SP's actions or the SP's denials, there was not a preponderance of the evidence whether the SP had sexual contact with the VA.

It was not determined whether 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).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate and followed. The report was not similar to prior concerns with the SP or any similar incident. There was no further action taken by the facility.

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

No further action taken.