**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:** 202305222

**Date Issued:** September 8, 2023

**Name and Address of Facility Investigated:**

REM North Star, Inc. - Miles
1007 Miles Avenue SE
Bemidji, MN 56601

REM North Star, Inc.
6600 France Avenue South, Suite 350
Edina, MN 55435

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

**License Number and Program Type:**

1071598-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071573-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) had a sexual relationship with a vulnerable adult (VA).

**Date of Incident(s):** Ongoing, prior to June 18, 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 and law enforcement records; and through interviews conducted with a facility staff person. The SP did not respond to requests for an interview. This investigator did not interview the VA because the VA was already interviewed by the facility and law enforcement.

The facility was a single level. The facility had a living room, a dining room, and a kitchen. The kitchen was on one side of the facility. There was a staff person office off of the kitchen. Next to the kitchen was a living room and on the opposite side of the living room from the kitchen, a hallway off of the living room led to four bedrooms.

The VA's support plans stated:

- The VA's diagnoses included a mild intellectual disability. The VA was not subject to guardianship.

- The VA was susceptible to sexual abuse and might not recognize that s/he was sexually abused so the VA might not report it.

- The VA had a history of embellishing stories and making false statements. The VA might state something that it is not true if s/he was upset with an individual.

- The VA was able to be home without staff person supervision for two hours. The VA was able to walk or ride his/her bike in the community without staff person supervision and spend time with friends without staff person supervision.

A supervisory staff person (P) provided the following information in a facility internal review report and to this investigator:

- On June 18, 2023, the VA was visiting a friend (F) and the F noticed concerning text messages on the VA's phone from the SP and notified the P. The F told the P that the SP and the VA were having sex at the facility and the text messages included a photo of genitals. The F sent the P nine photo messages and said that those were just from that day and added that there were hundreds of messages between the VA and the SP.

- The P asked the VA about the texts and photos and the VA told the P that s/he had a sexual relationship with the SP. The VA told the P that the sexual relationship was consensual, and had been going on "for a little bit."

- The SP worked overnights but also picked up extra shifts during the day. Four consumers lived at the facility. The VA had his/her own bedroom, but it was on the same side of the facility as the other bedrooms. The staff person office was on the opposite side of the facility from the bedrooms. The P believed that the SP and the VA could have sexual contact in the facility without the other consumers being aware.

A law enforcement report completed a law enforcement officer (LEO) stated:

- On June 23, 2023, the VA told the LEO that the SP told the VA that s/he wanted to do "something" with him/her but was too "chicken." A while later, the SP asked if the VA wanted to do "stuff." The VA clarified "sexual stuff." There were several incidents that occurred at the facility, both in the staff person office and the VA's bedroom. The VA said that s/he believed that the SP worked at the facility for one month and that the incidents happened for one week (at the time of the interview with law enforcement, the SP had worked at the facility for four months). The SP and the VA had sexual intercourse. The SP kept asking the VA to have sex, but did not use force. The VA said that the SP and the VA exchanged sexually explicit photos via text message.

- The LEO obtained numerous text messages between the SP and the VA dated from June 13 through 18, 2023. The phone number that the VA exchanged texts with matched the SP's phone number. The texts were sexual in nature and discussed the SP and the VA having various forms of sexual contact. There were also partially naked photos exchanged between the two including a photo of the SP's genitals (the LEO provided the texts to this investigator and the texts included the SP describing the sexual acts that s/he was going to do with the VA).

- The LEO was not able to contact the SP. The LEO made multiple attempts to reach the SP via telephone and went to the SP's home, but no one answered the door. The LEO referred the report for charges to the County Attorney for 3rd degree criminal sexual conduct.

The SP provided the following information in the internal review:

- The SP began work on March 11, 2023. The SP worked 11 p.m. to 8 a.m. three nights per week and every other Saturday. When the SP arrived to work, s/he checked everything at the facility and then went to sleep until about 6 a.m. At that time, the SP documented, helped the morning staff persons, and/or passed medications. The SP also occasionally worked additional shifts.

- The SP did not have a lot of interaction with the consumers despite the consumers being at the facility most of the time. The SP did not have any interactions with any of the consumers outside of work. The SP did not cross any boundaries with the consumers. The SP never received any calls or texts from any consumer. When the SP was asked if s/he had specifically texted the VA, the SP said that s/he did not. When the SP was told about texts messages that were observed between the SP and the VA, the SP said that did not "recall" sending any text messages to the VA.

- The SP confirmed his/her phone number and then was told that text messages sent to the VA came from his/her number. The SP stated, "This is the first I'm hearing about it." When the SP was told some of the content and asked about "inappropriate messages," the SP did not want to "say anything about that."

- When the SP was asked how a photo of him/her was on the VA's phone, the SP said that s/he let the VA watch some things on his/her phone, but s/he was "right there" so s/he did not know how the photos got the VA's phone. The SP was told that there was a photo of the SP not wearing a shirt and a photo showing genitals that came from the SP's phone. The SP responded, "Those pictures were sent to someone else."

- When the SP was told that the VA said that the two of them were having a sexual relationship, the SP said

that they watched television shows together and that they have "hung out." The SP said that the only time s/he was with the VA outside of work was when the VA needed a ride as the VA's bus scheduled was "screwy" and s/he needed a ride. The SP did not tell any supervisory staff persons and said that other staff persons picked the VA up when they were not working.

- The SP did not answer when asked for an explanation for the photos, the texts, and the VA's statement that they had a sexual relationship. The SP was aware that s/he could not engage in any type fo relationship with the VA even it was consensual. When asked if the SP was "denying everything," the SP said, "Yes, I am denying this."

- The SP was aware that law enforcement was trying to contact him/her.

This investigator attempted to contact the SP for an interview via telephone and written correspondence, including a certified letter, but the SP did not respond to the requests.

Facility documentation showed that the SP received training specific to the VA and on the Reporting of Maltreatment of Vulnerable Adults Act.

**Conclusion:**

A. Maltreatment:

The VA stated that the SP and the VA had sexual intercourse on more than one occasion. The VA provided texts messages between the VA and the SP which included sexually explicit content both written as well as photos. The SP provided the facility with inconsistent information regarding contact with the VA via texts and whether they had contact outside of work. The SP did not respond to the LEO's or this investigator's attempts to contact him/her for an interview.

The VA had a history of making false statements and embellishing stories. However, the text messages exchanged between the VA and the SP coupled with the SP making inconsistent statements lent credibility to the VA's statements that the SP had sexual contact with the VA. Therefore, 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:

(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 received training 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 abuse for which the SP was responsible was serious maltreatment because the SP had sexual contact with the VA and was recurring maltreatment because the SP had sexual contact with the VA on more than one occasion.

The SP was disqualified from providing direct contact services.

**Action Taken by Facility:**

The facility completed an internal review and determined that their 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.