

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: 202305883

Date Issued: September 8, 2023

Name and Address of Facility Investigated:

Disposition: Inconclusive

Northstar Behavioral Health
1174 Western Ave
Fergus Falls, MN 56537

License Number and Program Type:

1101848-SUD (Substance Use Disorder)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) and a vulnerable adult (VA) had a relationship while the VA received residential services that continued the weekend that the VA left the facility against staff person advice.

Date of Incident(s): July 9, 2023 and prior

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); and subdivision 17, paragraph (a):

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.

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 for this investigation was obtained remotely, including documentation from the facility and law enforcement records; and through six interviews conducted with four facility staff persons (the SP and P1-P3), the VA, and a facility client (C2).

The VA's diagnoses included depression, anxiety, post-traumatic stress disorder, opioid use disorder, and stimulant use disorder. The VA described his/her strengths as "hard working, smart, and teachable." The VA also believed s/he was in "great shape" physically.

P1 said that on Saturday, July 8, 2023, the VA left the facility against staff person advice. (Two days prior to his/her scheduled discharge.) After the VA left the facility, a client (C1) told P1 that s/he used the SP's phone and saw photos on the SP's phone that showed the VA and SP together, and that those photos were dated July 8, 9, and 10. C1 said that one of the photos showed the SP kissing the VA's cheek and C1 implied there was a sexual relationship because the VA and SP appeared to be together in a hotel room and a house. (C1 suggested it was the SP's house.) When this investigator asked P1 how to contact C1, P1 said that C1 "told [P1] these things in confidence and does not wish to be identified."

P2 provided the following information:

- While the VA was a resident at the facility, the VA was observed spending "excessive" amounts of time with the SP in the SP's office with the door both opened and closed. P2 said that the SP "did not have any reason to see the VA individually in [his/her] office." P2 observed the VA "overtly friendly" and "maybe even flirting" with the VA. When asked by this investigator how these concerns were addressed, P2 said s/he talked to a supervisory person (P3) about the SP and VA and said that staff persons were reminded of boundaries at weekly staff person meetings.
- On July 8, 2023, the VA left the facility against staff person advice, before his/her formal graduation that was scheduled for two days later. On July 10, 2023, P2 was speaking to a client (likely C1) who speculated the VA left the facility "ahead of time and without graduation" in order to spend time with the SP before the VA had to turn him/herself in to jail for a trial scheduled to start on Tuesday, July 11, 2023. After the VA left the facility that same client made "general reference" about the VA in a small group of peers and two other peers "nodded in acknowledgement" that there was "some sort of personal or unprofessional relationship between [the SP] and the VA." P2 said that the client who made the speculations and comments did not want to be identified.
- According to P2, the SP admitted that s/he "struggled with boundaries" when this was discussed. After the VA left the facility, P2 observed the SP having "additional and long visits" in his/her office with

“another client” and that those conversations “were not always professional.” (P2 provided an example of an interaction where an unidentified client came around a corner and attempted to “scare” the SP. The SP responded by swearing loudly and laughing. The client said s/he was “thinking” about the SP and wanted to see if the SP was in his/her office. The SP laughed and said, “At least someone is thinking of me.”

C2, a client who was at the facility with the VA, provided the following information:

- C2 “could tell [the VA and SP] were close, friend-wise,” but there was “nothing off until the end.” Prior to the VA’s discharge, the VA was in the SP’s office “constantly.”
- After receiving his/her graduation certificate, the VA left two days prior to his/her scheduled discharge date. C2 believed it was because the VA had some “legal stuff” going on and wanted to make sure s/he had his/her “ducks in order” before his/her trial began.
- After the VA left the facility, C2 heard “through the grapevine” that “someone” saw photos of the VA and SP kissing on the SP’s phone. C2 did not want to identify the name of the client who provided that information and said, “I don’t think [s/he] was lying.”
- C2 said that vape pens were contraband, and C2 believed that the SP brought them into the facility for a “couple people” including the VA.
- Around the beginning of July 2023, C2 believed the SP was actively using drugs due to his/her “physical features” and a staff person that C2 did not want to identify said that “their friend knew [the SP] had been buying dope.”
- Before the VA left the facility, s/he wanted to make sure s/he had “money on [his/her] books,” and the VA’s family member sent “a couple hundred dollars” to the SP’s cash app so that the SP could “put money on [the VA’s] books.” C2 did not know why the family member did not give the money directly to the VA. C2 also heard from an unidentified staff person about a time when the VA went into the SP’s office wearing only underwear on his/her lower body. After that incident, P3 reviewed a camera in the SP’s office and saw the VA “slapping [the SP’s] ass.”
- When C2 was asked about the amount of time C2 spent in the VA’s office, C2 said, “maybe more than average” and that the door was both open and closed during their meetings. C2 described the SP as “really understanding” and “has a big heart” but was “not fully professional.” The SP wanted to “see the good in others.”

P3 provided the following information:

- P3 “did not have a lot of concerns” about the SP’s boundaries although s/he addressed boundaries with the SP on two occasions. (Documentation confirmed two meetings regarding “boundaries.” At the first meeting around mid-June 2023, P3 “identified concerns with boundaries” and documented the SP was to “improve boundaries” and have “more awareness.” After that meeting, the SP’s office moved to an office with a window that was not as secluded as his/her initial office. At the second meeting approximately a

week before the VA left the facility, P3 again discussed "boundaries" with the SP that included a client (determined to be the VA) was "found with [the SP's] vape pen." The SP acknowledged that s/he was "not the most professional person."

- Although the VA had a graduation ceremony and received his/her certificate of completion on July 7, 2023, his/her discharge was scheduled for July 10, 2023. The VA left the facility on July 8, 2023, against staff person advice. Coincidentally, the SP was not scheduled to work July 8-10, 2023. Immediately after the VA's discharge, "clients started talking" and one unidentified client (likely C1) said s/he saw pictures of the VA and SP together in a hotel room.
- When asked about clients using staff persons' phones, P3 said that it was "not unusual" for clients to use the staff persons' work phones but it would be unusual to use a personal phone. However, due to the SP's job status, s/he was not issued a work phone until just prior to these allegations and the SP's work phone was never set up.
- As a result of the allegations in this report, P3 reviewed the camera located in the SP's office and observed that the VA was in the SP's office "a lot" despite the VA not being on the SP's caseload. However, P3 said it was possible some of their interactions were related to treatment. P3's camera reviews showed the VA going into a bag of the SP's personal belongings, and P3 saw the SP handing the VA a vape pen and the VA then took puffs of the SP's vape pen. (Vape pens were considered contraband and not allowed at the facility.) When asked about observing the VA slap the SP's butt (as told by C2), P3 did not recall seeing that.

The VA provided consistent information when interviewed by law enforcement and/or later when interviewed by this investigator:

- On Friday, July 7, 2023, the VA got his/her medallion and certificate of completion and decided to leave the facility the next day so that s/he could spend time with his/her family prior to "turning [him/herself] in to law enforcement on Monday, July 10, 2023. On July 8 and 9, 2023, the VA stayed at a hotel in the same town as a family member. (Law enforcement records confirmed s/he was in custody in that town on July 10, 2023.)
- Although the VA denied any relationship with the SP, the VA said that s/he "related closely" to the SP and went into his/her office to talk about things s/he did not feel s/he could talk about with his/her assigned counselor.
- The VA denied there were any photos taken of him/herself and the SP, denied any sexual contact with the SP, said that s/he was not with the SP and did not see or talk to the SP after the VA left the facility on July 8, 2023.
- After leaving the facility, the VA was at a community meeting and heard that the SP was "fired" for crossing boundaries with the VA.

The SP said that there "may have been a boundary crossed" because the VA was "probably in my office too much." The SP said they never kissed and denied a sexual relationship with the VA. After the VA left the facility,

an unidentified client told the SP that "someone else said" that they saw pictures of the VA and SP on the SP's phone. The SP denied having any pictures of him/herself and the VA on his/her phone and did not know why someone would say they saw such photos. Although the SP admitted vape pens were contraband at the facility and admitted that the VA and other clients took "hits" from the SP's vape pen which was "wrong," s/he denied giving any clients a vape pen. The SP said that s/he allowed clients to use his/her personal phone because s/he was not issued a work phone "right away" and clients used the SP's phone to look up jobs, call family members for money, or call their probation officers. The SP also denied that a family member of the VA sent the SP money for the VA.

Conclusion:

The Department of Human Services received information that the SP and the VA had a personal and sexual relationship. Information showed that although the VA was not on the SP's caseload, the VA spent a lot of time in the SP's office. After the VA left the facility two days prior to his/her scheduled discharge and against staff advice, C1 told P1 (and likely P2 and C2) that s/he saw photos of the VA and SP together and kissing on the weekend that the VA left. This investigator was not able to interview C1 because s/he wanted to remain anonymous.

Although the VA said that s/he "related" well with the SP and was able to talk to the SP about things s/he did not feel s/he could talk about with his/her assigned counselor, the VA denied any relationship with the SP, said there were no photos taken with the SP and no sexual contact, and said that s/he did not see or talk to the SP after the VA left the facility. The SP admitted that the VA was probably in his/her office too much but denied any kissing or a sexual relationship. The SP also stated that s/he allowed clients, including the VA, to take "hits" from the SP's vape pen which was not in accordance with the facility's policies.

Given that the information from C1 (photos, kissing, and being together after the VA left the facility) was not able to be corroborated, that the information from C2 was "heard through the grapevine" and also was not corroborated, and that the VA and SP each denied a relationship, there was not a preponderance of the evidence as to whether sexual contact between the SP and VA occurred. Likewise, although there was information that the VA and SP spent a lot of time together in the SP's office and that there were concerns regarding the SP's boundaries that may have been inconsistent with the standards of a professional caregiver in a DHS licensed facility, there was not a preponderance of the evidence whether the SP's behavior represented a failure to provide reasonable and necessary care and services to the VA.

It was not determined whether sexual abuse or neglect 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 and/or 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).

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate, were followed, and that there was no need for additional staff person training. The event was similar to past events at the facility concerning boundaries between staff persons and clients and boundaries were discussed during orientation, at staff meetings and in-services, and annual training. The SP no longer worked at the facility.

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

No further action taken.