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: 202303508

Date Issued: September 13, 2023

Name and Address of Facility Investigated:

Disposition: Inconclusive

Phyxius, Inc. Theta
613 54th Ave. N.
St. Cloud, MN 56303

Phyxius, Inc.
215 Park Ave. S.
St. Cloud, MN 56301

License Number and Program Type:

1115085-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071132-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) touched a vulnerable adult's (VA's) genital area.

Date of Incident(s): April 23, 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 was obtained during a site visit conducted on June 15, 2023; from documentation at the facility, law enforcement records, and medical records; and through four interviews conducted with two facility administrative staff persons (P1 and P2), the SP, and the VA's guardian (G).

The VA enjoyed swimming, cooking, singing, drawing, going on community outings, and spending time with family members. The VA's diagnoses included cerebral palsy, fetal alcohol syndrome, intellectual disability, and autism spectrum disorder. The VA was non-verbal and used gestures and some sign language to communicate.

According to the VA's *Person-Centered Planning Tool*, it was important to treat the VA with respect to maintain his/her dignity. The staff persons were to "always get consent from [the VA] to touch [his/her] body." According to the VA's *Person-Centered and Positive Support Strategies*, the VA required assistance with completing most steps of his/her daily routine, including personal cares and hygiene and getting dressed. According to the VA's *Individual Abuse Prevention Plan (IAPP)*, the VA had a lack of understanding of sexuality and would be unable to be assertive or to report abuse.

P1, P2, the SP, and the facility's documentation provided the following information:

- On April 23, 2023, the SP worked at the facility with P3. The SP stated that at approximately one hour prior to the end of his/her overnight work shift, the VA woke. The SP typically administered the VA's medications to the VA or prepared the VA's breakfast in the morning while the other staff person did the VA's personal cares. However, on that day, P3 prepared breakfast for the VA, so the SP assisted the VA with toileting and getting dressed for the day. The SP wore gloves and assisted the VA with removing his/her adult disposable brief, but the VA did not want to pull on a clean disposable brief so the SP assisted the VA with pulling up the adult disposable brief and adjusting it around the VA's genital area. The SP stated that while doing this, s/he touched the VA's genital area, but that it was not done in a sexual manner. While the SP pulled up the VA's disposable brief, the VA played with one of his/her toys and was laughing. The SP stated that in the past s/he did not have to touch the VA's genital area and doing so made him/her uncomfortable because the VA was the same gender as the SP. Two days after the incident, the SP told P1 about the incident.

- P1 stated that on an unknown date in April, the SP asked to talk to P1 and told P1 that s/he was not in a "good mental state" and needed time off. The SP then told P1 that two days earlier s/he had "intentionally" touched the VA's genital area, but then realized what s/he was doing and stopped. The SP did not provide any additional information to P1 about the incident. P1 stated that when s/he and P2 followed up with the SP, the SP told them that s/he "unintentionally" touched the VA's genital area. P2 stated that when s/he talked to the SP about the incident, the SP was very "vague" and did not provide detailed information about the incident and avoided talking about it, but the SP indicated that touching the VA in this instance was not for the purpose of assisting the VA with personal cares. P2 stated that the SP did not make a clear statement that s/he intentionally touched the VA's genital area or that s/he intended to touch the VA's genital area. None of the other staff persons working at the facility that day had any concerns about the SP's interactions with the VA. P1 stated that s/he had no previous concerns about the SP's interactions with the VA. The VA

was seen by his/her physician for a sexual assault evaluation. P1 stated that the VA had no noticeable emotional or physical distress.

According to the facility's *Rights of Persons Served Policy*, the residents had the right to be free from maltreatment and to be treated with courtesy and respect.

Facility documentation showed that the SP, P1, and P2 each received training on the Reporting of Maltreatment of Vulnerable Adults Act, the facility's policies, and the VA's plans prior to the incident.

Conclusion:

On April 23, 2023, the SP assisted the VA with dressing after the VA's shower. The SP provided information to this investigator, P1, and P2, that while assisting the VA, the SP touched the VA's genital area. The SP provided inconsistent information as to whether the touch was intentional or unintentional and it was unclear exactly how the SP touched the VA. The SP also told P1 and P2 that s/he was "not in a good mental state" at the time of the incident. The VA was non-verbal and unable to provide information about the incident. A medical examination showed that the VA had no noticeable emotional or physical distress after the incident.

Given that the VA was unable to provide information about the incident, that the SP provided inconsistent information about what occurred, that it was unclear if the touch was intentional or incidental during the course of therapeutic conduct, and that the VA did not experience any distress after the incident, there was not a preponderance of the evidence as to whether sexual contact between the SP and the VA occurred.

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 the facility's policies were adequate, but were not followed by the SP. The SP no longer worked at the facility.

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

No further action taken.