

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: 202202945

Date Issued: September 15, 2023

Name and Address of Facility Investigated:

Disposition: Inconclusive

Bell Hill Recovery Center
12214 200th Street
Wadena, MN 56482

License Number and Program Type:

800173-SUD (Substance Use Disorder)

Investigator(s):

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Office of Inspector General
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Suspected Maltreatment Reported:

It was alleged that a staff person (SP) had sexual contact with a vulnerable adult (VA) and gave the VA 23 methylphenidate tablets (common brand name Ritalin) which the VA "snorted."

Date of Incident(s): April 12 and 14, 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); 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 was obtained during a site visit conducted on April 28, 2022; from documentation at the facility and law enforcement records; and through three interviews conducted with the VA, a facility supervisor (P), and the SP.

The VA's diagnoses included alcohol use disorder and stimulant use disorder. The VA reported that s/he suffered from poor impulse control along with social stress and poor communication skills. The VA was prescribed Ritalin 20 mg tablets and was to take one per day. The VA enjoyed fishing and sports.

The facility had a medication office, which was also the SP's office. The office door locked, and the SP and other staff persons had a key to the office. The office had two windows that looked out into a hallway that had offices and a bathroom. Inside the office, there was a locked cabinet where medications were stored. In a facility administrator's office, there was an area in which medications that were discontinued and needed to be destroyed were kept until they were destroyed.

The VA was admitted to the facility on March 7, 2022, and was discharged on April 18, 2022, for a parole violation for "using a controlled substance and inappropriate behaviors during a visit with [his/her] significant other."

The VA provided the following information to this investigator:

- Soon after the VA was admitted to the facility, the SP called the VA to his/her office to obtain some of the VA's information including the VA's phone number. The VA left and 10 to 15 minutes later, the VA received a text message that said, "Hi." The sender did not identify him/herself but the VA "knew" it was the SP. After that, the SP was "flirty" with the VA and the VA stated that s/he had to "flirt" with the SP to "make [him/her] happy" because if the VA did not, the SP "might get [the VA] kicked out of" the facility. The SP would call the VA to his/her office when the SP "needed something," but the SP did not need anything and "just wanted to talk."
- When the VA needed to have his/her blood pressure checked in the SP's office, s/he could see down the SP's shirt. One occasion the SP fell toward the VA and touched the VA near the VA's "crotch." Other occasions the SP would touch the VA's "crotch" and the VA had his/her hands on the inside of the SP's thigh. The VA thought that happened "five or six times."
- On one occasion, the SP went to the VA's room, knocked on the door, and when the VA opened the door, the SP put the "top half" of his/her body into the VA's room, and they kissed.
- The day the VA had a medical appointment at a clinic around 8:30 a.m., (the VA did not recall the date, but information showed that it was an appointment on April 12, 2022) a staff person brought the VA to the appointment and then back to the facility. Around 9 or 9:30 a.m., the SP told the VA that s/he needed

to take the VA back to the clinic because they did not get enough blood from a blood draw. The VA "knew this was bull shit."

- Soon after, the SP left the facility with the VA and another client in the facility van. The SP dropped off the other client at a store the client needed to go to and then went to the clinic but parked "across the street in the corner." The SP "performed oral [sex]" on the VA for "a little bit." The VA stated that s/he "stuck my fingers down [the SP's] pants." The SP wanted to have sex, but the VA said, "No way." The VA told the SP that s/he better go into the clinic for his/her appointment, so the VA did not get in trouble. The SP told the VA that s/he "lied" about the VA having a second appointment. However, the VA thought s/he should go into the clinic anyway, so the SP dropped the VA off at the front door and waited in the van until the VA came back out. Then, the SP drove back to the store to pick up the other client and then back to the facility.
- The next day, the SP and the VA were talking about the VA's "drug use" and the VA told the SP that in the past, s/he had used "meth[amphetamines] and Ritalin." The SP told the VA that s/he heard that those drugs "make you really horny." The VA said that s/he "loves getting high and having sex." The VA then asked the SP to give him/her all of his/her Ritalin pills so s/he could "sniff a bunch" and then the SP and the VA could "sneak into" the P's office.
- The VA stated that the SP gave him/her the Ritalin pills and the VA "crushed a few and sniffed them" and was "feeling pretty excited." The SP went into the bathroom and the VA waited and then they went into the P's office. The VA stated that "this is on camera" because the VA and the P watched the footage and saw the SP and the VA go into the P's office. In the P's office the SP and the VA were "touching and feeling" each other including touching each other's genitals. The SP wanted to have sex on a desk in the office, but the VA said, "No," because s/he did not want to get caught. Then, they left the office. Nothing after that happened between the SP and the VA other than "maybe" a couple of text messages between the two.
- The next day, the VA's significant other visited the VA at the facility. The VA was not supposed to touch his/her significant other but was doing so anyway. Later, a staff person told the P that the VA was being inappropriate. The VA thought that staff person "got me in trouble" because that staff person "had a thing for me too." The next day, the P told the VA that s/he was inappropriate so the significant other's visits would be restricted. Then the VA told the P that if the P was going to "fuck with" the VA's visits, the VA would "play that card" about what the SP was doing to the VA. The VA told the P about the sexual contact between the SP and the VA and about the SP giving the VA the Ritalin. The P told the VA that s/he would have to contact the VA's parole office and those things would violate the VA's parole.
- The VA was then arrested and went to jail. The VA stated that prior to that, s/he erased all the text messages and photos between the VA and the SP from the VA's phone.
- The VA stated s/he told a law enforcement officer what happened with the SP. The VA stated that "more happened" than what the VA told the law enforcement officer which was why s/he told this investigator more. The VA told the law enforcement officer the "main stuff."

The P provided the following information:

- On April 18, 2022, the VA told the P that on April 12, 2022, the VA had a medical appointment. The SP took the VA back to the clinic but parked in a parking lot on the backside of the building which the VA told P1 was "not the normal place." The SP then "rubbed" the VA's "crotch" and performed oral sex on the VA while in the facility van. Then, they returned to the facility and the SP told the VA to "make sure" that s/he took a shower.
- The VA then told the P that on April 14, 2022, the SP called the VA into his/her office and offered the VA his/her "pills" (methylphenidate 20 mg) that were prescribed to the VA but had been discontinued. There were 23 tablets remaining. Then, they both left the SP's office and crossed the hallway and entered the P's office. The SP unlocked the door previously and they entered the office and shut the door for about five minutes. When they left the office, the VA went to his/her room, removed the pills from the package, and then returned the package to the SP. The VA "knew" that would be a violation of his/her parole but took them anyway. The VA "snorted" the pills and there were none left.
- On April 18, 2022, the P talked to the SP. The SP told the P that s/he did not know why s/he was "accused" of "sexual assault" of the VA. The P asked the SP where the VA's methylphenidate pills were. The SP told the P that s/he placed them in a pill bottle and the bottle was on the SP's desk or in the "metal cabinet" in another area of the facility. The P asked the SP why the VA said that the SP gave the pills to him/her. The SP told the P, "Well maybe [the VA] took them off my desk. I guess it doesn't matter if I gave them to [him/her] or [s/he] took them. I should have had more control over them." The P stated that the SP should not have left the medications unlocked on his/her desk.

A law enforcement report provided the following information:

- On April 18, 2022, the P talked to the VA about an unrelated incident. During that conversation, the VA told the P that s/he had "information" that could "get people in trouble." The VA was "reluctant" to tell the P but eventually told the P that s/he had been "sexually assaulted."
- The P told law enforcement that on April 12, 2022, at 10 a.m., a staff person brought the VA to an appointment at a clinic, and they returned shortly after. At 11 a.m., there was a staff person meeting. Around 11:30 a.m., the SP told the P that the clinic called and wanted the VA to come back to the clinic for another blood draw. The P thought that was "odd" but did not question it. The SP offered to drive the VA to the clinic and bring another client to a store. Law enforcement talked to the client who said that the SP dropped him/her off at the store and left with the VA. They returned about 20 minutes later to pick the client up. The client did not observe any suspicious behavior between the VA and the SP.
- The VA stated that when the SP and the VA were parked in the back parking lot of the clinic, the SP began to "fondle" the VA's genitals and then performed oral sex on the VA for "a few minutes." The VA's "ankle monitor" showed that at 12:52 p.m., the VA was in the west parking lot of the clinic. The VA stated that s/he then went into the clinic for a period of time to "tip off" his/her parole agent if s/he did not go into the clinic.

- The VA stated that on April 14, 2022, the VA told the SP that s/he wanted to discontinue taking Ritalin, so the SP told the VA to go to the SP's office. Then, the SP asked the VA if s/he wanted the remaining 23 pills, so the VA took them. The VA stated that there was no medication left because between this date and the date s/he was arrested, s/he snorted the pills.
- The P told law enforcement that s/he saw video from April 14, 2022, of the SP and the VA going into the P's office. The P stated that there was no reason that either the SP or the VA should be in the P's office without the P being present. The VA was left alone in the P's office with confidential files. The P stated that the SP first went and unlocked the P's office, went to the staff person bathroom, and then went to the SP's office. The VA went into the SP's office and then the SP went into the P's office and the VA followed in behind him/her. The SP and the VA were in the P's office for about five minutes. When they were about to leave, a client approached from down the hallway, so the door shut, and the client passed. Then, they came out of the office.
- The VA stated that while they were "in the office," that "kissing and groping of each other's bodies went on." The VA could not remember if s/he touched the SP over the top of his/her clothing or the SP's "private areas." Then VA stated that if s/he did touch the SP it was never underneath the clothing but over the top of clothing. The VA stated they were in the office for about five minutes.
- The VA also told law enforcement that when the SP and the VA were in the P's office was when the SP gave the VA the rest of his/her prescription Ritalin that s/he had discontinued taking as of April 14, 2022. The medications were supposed to be put in the lock up container located in a different building. The VA told law enforcement that the SP gave him/her all his/her 23 Ritalin 20 mg tablets.
- On April 14, 2022, the SP documented on a medication log that the VA's 23 Ritalin tablets were placed in a lock up container in an administrator's office and the SP signed it. Next to the lockup container was a drug destruction log of the medications that were set to be taken to the Sheriff's Office to be destroyed. The VA's Ritalin was not listed on the destruction log.

The SP provided the following information:

- One occasion (the SP did not recall the date), the VA had an appointment and after the VA returned to the facility, the clinic called the SP and said they did not get all the blood they needed so the VA needed to go back to the clinic. Another client needed to go to the store, so the SP took the client and the VA in the van. The SP dropped the client off at the store and then drove to the clinic. The SP dropped the VA off at the clinic door and then waited in the parking lot. Shortly after, the VA walked out so the SP picked the VA up, then picked up the client at the store, and they returned to the facility. The SP stated that the VA was talking about past sexual encounters and "talking sexual" the "entire" time. The SP denied sexual contact of any kind with the VA.
- Sometime later that day or after that day (the SP could not recall when), the VA told the SP that s/he wanted to stop taking Ritalin. The SP told the VA that s/he could not just stop taking medications and needed a doctor's order. The SP sent a fax to the VA's provider about discontinuing Ritalin. The SP took the VA's Ritalin bottle out of the locked box and put it on his/her desk to wait for the response from the VA's provider. Then, the SP left the office to take clients to an appointment. When the SP returned, s/he

did not recall seeing the medication bottle and was not sure if another staff person administered other medications to clients and put the bottle somewhere or left the door to the office open. A "couple of" days later, the SP received a call asking where the medication bottle was, and s/he said it was on his/her desk or locked up in the administrator's office. The SP denied giving the VA the Ritalin pills.

- On occasion, the SP went into the P's office to get coffee and sometimes the VA follow so the SP told the VA that s/he needed to leave the office. The SP did not recall the date but stated that the VA asked the SP to find him/her a number for the VA's probation officer because the VA needed to contact him/her. The P was not at the facility and the SP thought the number for the VA's parole office was in the P's office. The SP went into the P's office and soon after, the VA also went into the P's office. The SP told the VA s/he could not be in the office and to leave. The SP got the number for the VA. The SP went back to his/her office and the VA went back to his/her room. The SP denied sexual contact with the VA in the office or on any other occasion.
- Every time the VA walked past the SP's office when the SP was in it, the VA would make "comments" or "sexual innuendos." One example was the VA told the SP that the SP's eyes "are telling me you want to fuck me." The SP told the VA, "No," and then the VA walked away. The VA would "come up with something" like that his/her heart was racing so s/he needed his/her blood pressure checked so that the VA could get into the SP's office. Then, the VA would say his/her heart was "fine" and that the VA "just wanted to have sex on the desk," or something similar. One occasion, the VA told the SP that s/he had a "spot" on his/her groin area that s/he needed looked at. The SP told the VA that s/he would make the VA an appointment with his/her provider. The VA told the SP that s/he "needed" the SP to look at it, but the SP told the VA, "No." The SP stated that s/he told the P that the VA was making comments and the P told the SP if the SP "wasn't being hurt or afraid it wasn't a big deal."
- The VA told another staff person to leave his/her significant other and "come to" the VA. The SP heard the VA make other comments but did not recall what the comments were. The SP heard that the VA was going to accuse another staff person of "something" but that staff person "went straight to" law enforcement. Shortly after that, the VA "made the accusations against" the SP.

Facility records showed that on April 14, 2022, at 9:50 a.m., the SP sent a fax to the VA's provider that stated that the VA wanted to stop taking methylphenidate (Ritalin) 20 milligrams daily. The SP asked if the VA could "just stop taking" the medication. On April 14, 2022, the SP documented "placed in lock up...23 tab[let]s," on the medication log for the VA's Ritalin. On April 15, 2022, the provider replied, "Yes, [the VA] should not need to taper off."

This investigator reviewed video surveillance from the facility from April 14, 2022, beginning at 3:41 p.m. The video shows a hallway with doors to offices on each side. On the right side, first was a staff person bathroom and then a medication office which was also the SP's office. On the left side was first a staff person office, then the P's office, and then another office. The video showed the following:

- At 3:42 p.m., the VA entered the medication office.
- At 3:47 p.m., a staff person walked down the hall and went into the first office on the left.

- At 3:49 p.m., the SP and the VA left the medication office together. The VA walked down the hallway out of the video and the SP went into the staff person bathroom and shut the door.
- At 3:51:51 p.m., the SP went out of the bathroom with a coffee cup in hand to the P's office, unlocked the door, and entered the P's office.
- At 3:52:06 p.m., the VA walked down to the end of the hallway and sat in a chair. At 3:52:26 p.m., seconds later, the SP went out of the P's office without the cup leaving the door open and went to the medication office, unlocked the door, and talked to the VA. Then, the VA stood up and they both entered the medication office.
- At 3:54:38 p.m., the VA left the medication office and went into the P's office. Then the SP left the medication office shutting the door behind him/her and went into the P's office. The door was then shut.
- At 3:57:33 p.m., the P's office door opened slightly, a person walked down the hallway, and the door closed.
- At 3:58:39 p.m., the P's office door opened, and the VA went out with a paper in his/her hands. The VA said, "I'll put this number in my phone then I will be able to get a hold of parole." The VA stepped back in the doorway and said, "I think they changed their numbers." The VA asked the SP if s/he was going to go somewhere that day but was not intelligible. The VA then said, "Thanks," and walked down the hallway out of view of the video.
- At 3:59:08 the SP went out of the P's office with the cup and back into the staff person bathroom. At 3:59:44 p.m., the SP went back into the medication office.
- At 4:03 p.m., the SP left the medication office, stopped to talk to a person in the left office and then appeared to be leaving having his/her coat on and bag in his/her arms.
- At 4:09 p.m., a staff person entered the SP's office/medication office, administered a client medication, and then left the office.

Law enforcement investigated and sent a report to a county attorney, but charges were declined, and the investigation was closed.

Facility documentation showed that the SP and the P were each trained on the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

The VA was admitted to the facility on March 7, 2022, and was discharged on April 18, 2022, for a parole violation for "using a controlled substance and inappropriate behaviors during a visit with [his/her] significant other."

The VA stated that while in the medication office, the SP touched the VA's genitals, and the VA touched the SP's inner thigh. The VA thought that happened five or six times. The VA stated that when the SP brought the VA to

an appointment in the facility van, the SP performed "oral sex" on the VA and the VA touched the SP's genitals. The SP denied any sexual contact with the VA and stated that the VA made sexual comments toward the SP and talked about sex often.

The VA stated that two days later, the SP gave the VA 23 Ritalin pills. The VA provided different information to this investigator, the P, and law enforcement. The VA told this investigator that the VA asked the SP for his/her Ritalin so the VA could "sniff a bunch" and then the SP and the VA could "sneak" into the P's office. The SP gave the VA the Ritalin and the VA crushed "a few and sniffed them." Then, the SP and the VA went into the P's office and touched each other's genitals. The SP wanted to have sex, but the VA said, "No," because s/he did not want to be caught. The VA told law enforcement that the SP and the VA went into the P's office and kissed and "groped" each other but that the VA was not sure if s/he touched the SP's "private areas" and if s/he did it was not underneath the SP's clothing. After, the SP gave the VA the Ritalin pills in the P's office. The VA did not have any left at the time of discharge from the facility because s/he used them all. The VA told the P that after the SP and the VA were in the office, the VA went back to his/her room with the Ritalin pills. The VA "snorted" all of the pills.

The SP stated that the VA asked the SP if s/he could stop taking Ritalin. The SP told the VA that s/he needed to ask the VA's provider so on April 14, 2023, at 9:40 a.m., the SP sent a fax to the provider that asked if the VA could stop taking Ritalin. The SP stated that s/he had the Ritalin pills in a bottle on the desk in the medication office. The SP left the office at some point and then when s/he returned s/he did not recall seeing the bottle on the desk. Others had access to the office and the SP stated someone else could have moved the bottle or left the office door open. Sometime after, the VA asked the SP if s/he could help the VA find the number for the VA's probation officer. The SP thought the number would be in the P's office so went in to get it. The VA also went into the P's office and the SP told the VA s/he could not be there. The SP found the number and gave it to the VA and the VA left the office back to his/her room. The SP denied sexual contact with the VA and denied giving the VA the Ritalin pills.

Video footage from April 14, 2023, showed that the VA was in the medication office with the SP. The VA and the SP left the office, the SP went to the bathroom and the VA walked out of view down the hall. Two minutes later, the SP went into the P's office. One minute after that, the VA walked down the hall and sat in a chair. Shortly after, the SP went from the P's office to the medication office and the VA followed. Then, the VA went into the P's office and the SP followed. A few minutes later, the VA left the office with a piece of paper and thanked the SP for finding the parole officer's number.

Regarding sexual contact between the VA and the SP:

Although the VA stated that the VA and the SP had sexual contact in the van, in the medication office, and in the P's office, and the SP had reason to minimize his/her actions, given that the SP denied any sexual contact with the VA, that the VA provided different information to this investigator, the P, and law enforcement regarding what happened, that the medication office had two large windows looking into the hall, and that there was no further information to confirm or dispute either account, 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).

Regarding the VA's 23 Ritalin tablets:

Although the VA stated that s/he accessed and took the 23 Ritalin tablets subsequently "snorting" them and the SP had reason to minimize his/her actions, given that the SP denied giving the VA the Ritalin and said s/he might have left the bottle on the medication desk, that several staff persons had access to the medication office, that the SP documented that s/he moved the Ritalin to "lock up," and that the Ritalin was not found, there was not a preponderance of the evidence whether there was a failure to provide the VA with reasonable and necessary care and services.

It was not determined whether neglect occurred (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 were adequate but 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.