

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: 202309109

Date Issued: February 2, 2024

Name and Address of Facility Investigated:

RS Eden/Eden House
1025 Portland Ave S
Minneapolis, MN 55404

Dispositions:

Allegation One: Inconclusive
Allegation Two: Inconclusive

License Number and Program Type:

1003334-SUD (Substance Use Disorder)

Investigator(s):

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Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

Allegation One: It was reported that a staff person (SP1) had sexual contact with a vulnerable adult (VA1).

Allegation Two: It was reported that a staff person (SP2) had sexual contact with a vulnerable adult (V2).

Date of Incident(s): Unknown

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 through six interviews conducted with two facility staff persons (SP1 and SP2), two supervisory staff persons (P1 and P2), an administrative staff person (P3), and another client (C1) who received services from the facility. Attempts were made via telephone and/or mail to contact and interview VA1, VA2, and three other clients (C2-C4) who also received services from the facility, but the attempts were unsuccessful. VA2, C2, C3, and C4 each provided information to various staff persons and that information was included below.

VA1 and VA2 moved to the facility seeking supports and services related to their substance use disorders in August and June 2023, respectively. The facility provided residential treatment for individuals seeking recovery from substance use disorders. Services included, group and individual therapy, medication-assisted treatment, peer support services, independent living skills support, among others.

The facility's policy, "Guidelines for Professional Conduct – Standards of Conduct" stated, "romantic or sexual relationships between employees and clients, and clients and interns are prohibited" and "employees will have no contact, other than incidental, with a client [...] except for those activities which are an approved, integral part of the [facility's] program and a part of your job description."

Allegation One: *It was reported that SP1 had sexual contact with VA1.*

P3 that on October 27 s/he was told by an administrative staff person that C2 received a video from C3 that depicted SP1 having sexual intercourse with VA1 and that C2 showed C1 the video. P3 then spoke to C2 who stated it was not a video but a still photo. C2 told P3 that s/he deleted the photo and had no way of restoring it. P3 then spoke to C1, C1 stated that C2 showed him/her a video of two people having sexual intercourse, and one of the people in the video appeared to be SP1. Both C1 and C2 believed the person in the video was SP1 because they both had the same color of hair. C1 thought that the other person in the video was VA1 based on skin color and C2 thought it was VA1 because the person "looked like a picture [s/he] saw" of VA1. P3 called C3 and requested that C3 send him/her the video that s/he sent C2, but C3 refused.

C1 stated that on an unknown date, C2 told him/her that C2 had a video from C3 that "had [SP1] in it," and showed C1 the video. C1 said the video was "[SP1] having sex with somebody, some [person] that was here." During the video, one person "looked back," and saw the person's face and determined it was SP1. C1 could not identify the other person in the video but provided a description of what the person looked like. C2 told C1 said s/he erased the video and did not send C1 a copy of the video.

P1, stated that s/he was told about the allegations by P3. P1 did not have concerns regarding SP1 and professional boundaries and did not have any further information about the allegations.

SP1 stated that a client of the program received "media" on his/her phone from another client. SP1 heard his/her name mentioned and asked P3 for more information. P3 told SP1 that s/he was alleged to be in a video of two people having sexual intercourse. SP1 stated that s/he never communicated with clients outside the facility, never met with clients outside of the facility, and never had sexual contact with a current or former client.

Facility documentation showed that SP1 was trained on the facility's guidance on professional conduct and the

Reporting of Maltreatment of Vulnerable Adults.

Conclusion Allegation One:

Although C1 stated that s/he saw a video of SP1 having sexual contact and that it was thought that the contact was with VA1, given that no person saw the faces of the individuals and could identify the SP and VA1 based on hair and skin color, that the video was not available to confirm any information, that VA1 did not provide information for this report, and that SP1 denied the allegation, there was not a preponderance of evidence whether sexual contact between SP1 and VA1 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).

Allegation Two: It was reported that SP2 had sexual contact with VA2.

P2 provided the following information to this investigator:

- On September 19, 2023, C4 told P2 that on one occasion between September 7 and 11, 2023, s/he heard "moaning" coming from VA2's bedroom. C4 peeked into VA2's bedroom and saw SP2 and VA2 lying on a mattress. C4 could not recall if the lights were on or off and did not provide further information. C4 told P2 that after the incident, VA2 was "bragging" about having sexual relations with SP2.
- C3 then told P2 that VA2 stated, "You see [him/her] over there? [referring to SP2] That's my bitch." C3 also said that VA2 was known to "make up stories." C3 "knew for a fact" and "just knows it's happening" that VA2 and SP2 were having sexual contact but had never personally witnessed any "inappropriate conduct."
- P2 and P3 spoke with VA2 who said, "Nothing is going on at all." VA2 stated SP2 worked with him/her to order shoes and that SP2 kept VA2's passwords and information "in the event [s/he] forgets something."

P2 spoke with SP2, who denied the allegations. P2 had no concerns regarding SP2 and professional boundaries.

SP2 stated s/he never communicated with any client outside of the facility and never had sexual contact with a current or former client.

P3 stated that s/he was informed of the allegations by another administrative staff person but did not have further information about the allegations.

Facility documentation showed that SP2 was trained on the facility's guidance on professional conduct and the Reporting of Maltreatment of Vulnerable Adults.

Conclusion Allegation Two:

Although C4 told P2 that VA2 "bragged" about having sexual contact with SP2 and that C4 said that on one occasion s/he heard moaning from VA2's room and saw SP2 and VA2 lying on a mattress, given that there was no additional information provided regarding what SP2 and VA2 were doing on the mattress, that VA2 denied the allegation to P2 and P3, and that SP2 denied the allegation, there was not a preponderance of the evidence

whether sexual contact between SP2 and VA2 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 investigation and found "no evidence of misconduct." The facility completed an internal review of each allegation and determined that their policies and procedures were adequate and followed. SP1 was retrained on professional boundaries and reminded to "dress professionally" while at work. SP2 received additional training on "Ethical Conflict Resolution."

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

No further action taken.