

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: 202401469

Date Issued: March 20, 2024

Name and Address of Facility Investigated:

Disposition: Inconclusive

Cochran Recovery Services, Inc.
2000 White Bear Ave. N.
Maplewood, MN 55109

License Number and Program Type:

800611-SUD (Substance Use Disorder)

Investigator(s):

Scott Brandt
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
scott.j.brandt@state.mn.us
651-431-6556

Suspected Maltreatment Reported:

It was reported that a staff person (SP) had a romantic relationship with a vulnerable adult (VA) while the VA received services at the facility.

Date of Incident(s): Prior to February 16, 2024

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 through seven interviews conducted with the VA, the SP, the SP's significant other (SO), the VA's family member (FM), a management staff person (P1) and two facility staff persons (P2 and P3).

Facility documentation showed that the VA received services at the facility from September 22, 2023, through November 22, 2023. During that time, the SP was employed at the facility. At the time, the program was in Hastings, Minnesota. Documentation also showed that the VA was working toward his/her recovery and that the VA had a history of using alcohol and other substances.

P1 said that on February 16, 2024, P1 received a call from the FM. The FM told P1 that the SP and the VA had a "romantic relationship" for a "long time," but the FM did not provide a timeline to P1. The FM also told P1 that the VA was "in love" with the SP. As a result of the call, P1 called the SP and advised him/her of the allegations and the SP "denied it." P1 stated that no client or staff person had brought concerns forward to P1 regarding the SP's work performance or issues related to maintaining professional boundaries with clients. In addition, P1 did not have concerns related to the SP's work performance.

The FM provided the following information:

- The FM was not certain of the exact time frame, but thought that in November 2023, the SP began coming over to the FM's house to see the VA. After the VA left the facility, the SP spent the night with the VA in the VA's bedroom between two and five times. The VA did not tell the FM the nature of the relationship with the SP.
- When the FM asked the VA why they could not go to the SP's home, the VA told the FM that was not possible because the SP lived with his/her SO.
- On one occasion, the FM "confronted" the SP because the FM learned that the SP was a staff person at the facility. When that happened, the SP said, "I had it wrong," and that the SP "would help support" the VA.
- The FM also stated that the SO called the VA and was "threatening" him/her.

The VA provided the following information:

- The VA described the SP as a "friend" while the VA was at the facility. The VA also described it as a "professional friendship." When the VA left the facility, the VA "pursued" the SP by asking the SP for his/her phone number. After the VA had the SP's phone number, the SP and VA began to text message one another. The VA described the text messages as being "random" and discussing the VA's "sobriety."

When this investigator asked the VA if s/he would share the content of the messages with the investigator, the VA said, "No, I don't think it's necessary."

- The VA denied that the SP stayed over at the FM's home or that they engaged in sexual contact while the VA was at the facility. However, the VA stated that the VA and the SP engaged in sexual contact at the SP's home, which began two to three weeks after the VA left the facility.
- The VA did not provided details of the sexual contact that occurred.
- The VA denied that the SP contacted the VA.
- At some point, the SP made the decision to end the relationship with the VA and the VA "respected that" because they "both" agreed "it was a mistake" and that the VA "should never have pursued" the SP.

P2 and P3 each stated that they did not have concerns related to the SP's work performance at the facility and did not see the SP interact with the VA any different than how the SP interacted with the other clients.

The SO denied calling and threatening the VA and denied any knowledge of any type of relationship between the SP and the VA.

The facility had a policy on *Personal Involvement with Clients* which stated, "It is the policy of [name of facility] that no employee is to engage in sexual contact with current or former clients (a person that was enrolled in any [name of facility] program within two years of suspected sexual contact)."

The SP provided the following information:

- When the VA received services at the facility, the SP denied any type of a relationship with the VA. After the VA left the facility, the SP saw the VA in the community in the middle of December 2023. When that happened, the VA asked the SP for his/her phone number. After that, the SP and the VA began texting one another. The content of the text messages was the SP and the VA talking about each other's family members.
- When the SP was asked to provide the content of the text messages between the SP and the VA, the SP stated that s/he had deleted all text messages.
- On one occasion after the VA left the facility, the SP and the VA "hung out" at the FM's home for about one and a half hours and it was "really awkward" because the VA told the SP that the FM wanted to "meet" the SP. When that happened, the FM began "yelling at me" and saying that s/he did not "like" the SP. The FM told the SP that s/he was "disrespecting" the FM by being in the FM's home. When that happened, the SP became "uncomfortable" and wanted to "leave." The SP left the FM's home. The SP denied spending the night at the FM's home and having sexual contact with the VA.
- After the SP left the FM's home, the SP ended communication with the VA, but the VA continued to text the SP and it got to the point that the SP "blocked" the VA's phone number and thought that s/he would have to get a "restraining order" against the VA, but the SP did not do that.

- When the SP was asked what training s/he received in terms of staff persons having personal relationships with clients, the SP stated that s/he was trained to not have contact with clients for “up to a year” after the client left the program. The SP acknowledged that his/her actions were inconsistent with that training and that the SP should not have given his/her phone number to the VA or begin communicating with the VA.

The facility's *Internal Review* showed that the FM “offered” a photograph of the VA and the SP, taken on an unknown date at the FM's home.

The photograph showed the VA and the SP hugging one another at the FM's home.

The facility's training records showed that all staff person interviewed were trained on the Reporting of Maltreatment of Vulnerable Adults Act

Conclusion:

On February 16, 2024, the FM told P1 that the SP and the VA had a “romantic relationship” for a “long time” and that the VA was “in love” with the SP. The FM told this investigator that in November 2023, the SP began coming over to the FM's house to see the VA and stayed overnight two to five times in the VA's bedroom. The FM also stated that the SO threatened the VA, but the VA and SO denied that happened.

The VA denied that any type of relationship occurred while the VA was at the facility but stated that the SP and the VA had sexual contact at the SP's home after the VA left the facility. The SP denied any sexual contact.

The SP acknowledged that s/he gave his/her phone number to the VA after the VA left the facility and that they began texting one another, which was inconsistent with the training the SP received from the facility. The SP went to the FM's home one time, but left shortly thereafter when the FM became upset with the SP. The SP stated that s/he ended the contact with the VA at that point.

Although it was likely that there was sexual contact between the SP and the VA based on statements from the FM and the VA, the sexual contact occurred after the VA left the facility when the VA was no longer considered a vulnerable adult. In addition, P1-P3 did not see anything concerning between the VA and the SP when the VA received services at the facility. Given this, and that the VA and SP each denied having a relationship other than professional while the VA received services from the facility, there was not a preponderance of the evidence whether the SP had sexual contact with the VA while the VA was receiving facility services and there was not a preponderance of the evidence whether the SP failed 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; 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, but not followed (the review did not indicate what was not followed). In addition, no additional training was needed. The SP was no longer employed by the organization.

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

No action taken at this time.