

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: 202403306

Date Issued: May 30, 2024

Name and Address of Facility Investigated:

Disposition: Inconclusive

Northstar Behavioral Health North End
924 Rice St.
St. Paul, MN 55117

License Number and Program Type:

1114045-SUD (substance use disorder)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA) left the facility during the overnight to have sexual contact with a staff person (SP).

Date of Incident(s): Prior to April 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 was obtained during a site visit conducted on May 2, 2024; from documentation at the facility and through five interviews conducted with a management staff person (P1), a facility staff person (P2) and three clients (C1-C3). Although this investigator contacted another client (C4), another staff person (P3), the VA, and the SP, each did not respond to requests to be interviewed.

The facility provided residential services to clients with a variety of substance abuse disorders.

The VA's *Diagnostic Assessment* showed that the VA was diagnosed with depression, anxiety, and post-traumatic stress disorder. In addition, the VA had "problems" with substance use. The VA was not subject to guardianship.

P1 provided the following information in an interview and in his/her written documentation:

- The VA received services at the facility between January 23 and April 9, 2024.
- For a period of around five days in April 2024, the facility had an outbreak of Covid-19 and due to that, restrictions were in place to limit/reduce the clients from leaving the facility.
- On April 16, 2024, P3 told P1 that C4 told P3 that s/he had some concerns that something might be going on between the VA and the SP. As a result, P1 talked to C4 and other clients. Although C4 did not see anything, C3 told C4 that the VA had left the facility at least one time during the overnight shift and that C3 believed that the VA was having sexual contact with the SP. C3 thought that s/he saw the VA returning to the facility in the SP's personal vehicle. C4 also told P1 that the VA spent an "abnormal amount of time" in the SP's office, but C4 did not provided additional information. As a result of P1's discussion with C4, P1 talked to C1-C3. Also, P1 tried to obtain information from the VA, but the VA did not respond to P1's requests.
- C1 told P1 that s/he had not seen or heard of anything going on between the SP and the VA.
- C2 told P1 that the VA was "always" in the SP's office and C2 believed that the SP was the VA's significant other because the VA "made veiled comments about it all the time" and because the SP and the VA wore "matching bracelets."
- C3 said that the SP was "always" in the SP's office, and it was "obvious what was going on" and that the SP gave the VA "special treatment." C3 also said that when the VA "went on a pass," the VA returned with "hickies" on the VA's neck. C3 also said there was one morning when nobody could locate the VA, but when the SP got to work that morning, the VA "appeared from around the corner by where [the SP] parked."

- As a result of the information obtained, P1 reviewed camera footage (which was also reviewed by this investigator) and although camera footage did not show when the VA left the facility, it showed the SP driving his/her vehicle past the parking lot on April 9, 2024, at around 8 a.m. The car then turned and went off camera range for a brief period. A minute or so later, the SP drove into the parking lot and as that happened, the VA was seen walking down the street, toward the facility, from the same direction as when the SP's car went out of range. P1's review of camera footage last showed the VA within the facility at 11:30 p.m. on April 8, 2024.

The facility's *Client Observation and Head Count Log* showed that the VA was "present on property" at 4:15 p.m., 6:40 p.m., 9:53 p.m., and 11:37 p.m. on April 8, 2024, and at 1:20 a.m., 3:17 a.m., 4:19 a.m., and 5:51 a.m. on April 9, 2024.

C1 told this investigator that s/he had not observed any interactions between the VA and the SP that were concerning to C1. C1 also said that s/he was not aware of a time that the VA left the facility during the overnight hours.

C2 said that the last week the VA was at the facility (around April 9, 2024), the VA used "slang terms" to indicate to C2 that the VA had sexual contact with the SP and that the VA was "bragging" about it when the VA told C2.

C3 said that s/he saw the VA and the SP sitting next to one another and "telling secrets." C3 also stated that the SP had a history of sharing "personal things" with clients. C3 gave an example in which the SP told clients that s/he "started hooking up" with a client from a "different facility." C3 did not remember the date, but remembered one time when C3 was outside and the VA "came running" from the back of the building (the video reference earlier did not show which door the VA entered the facility from) "pretty early" in the morning and when C3 went inside, the SP came in the front door.

P2 described the VA as being a "very demanding client" and said that the SP initially shared some of those same concerns with P2 and that the SP seemed to spend more time with the VA in the SP's office over time and that some of those times, the office door was closed. At some point during the facility lockdown (April 2024), the SP's demeanor toward the VA changed and the SP began referencing the VA as "baby" when the SP talked to the VA. Also, the SP told P2 that s/he had a significant other toward the end of the VA's stay at the facility, but the SP did not provide detailed information about that to P2.

The facility's internal review showed that when the SP was interviewed on an unspecified date, the SP "denied" the allegations.

The facility's training records showed that all staff persons interviewed for this investigation, including the SP, were trained on the Reporting of Maltreatment of Vulnerable Adults Act prior to April 16, 2024.

Conclusion:

On April 16, 2024, P1 became aware of concerns related to the SP and the VA's interactions. As a result, P1 conducted internal interviews and reviewed camera footage. P1 learned that there was one instance, April 9, 2024, in which the VA returned to the facility in the morning at about the same time the SP got to work and that the SP's interactions with the VA might not have been professional. Information obtained by this investigator

provided similar information in that the SP might have exhibited inappropriate boundaries with the VA, but no one saw or reported sexual contact between the VA and the SP.

Given that there was limited information, that the VA and the SP each did not provide information, and that no one witnessed sexual contact or a further relationship between the SP and the VA, there was not a preponderance of the evidence whether the VA and the SP had sexual contact or whether the SP failed to provide the VA with reasonable and necessary care and services.

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 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 although policies and procedures were adequate, they were not followed because "this clinician did not report witnessing the client in question returning from off property despite video footage of [him/her] witnessing the event," but the name was not identified. Also, no additional training was needed, and the SP was no longer employed by the facility.

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

No further action taken.