

**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:** 202403252

**Date Issued:** June 28, 2024

**Name and Address of Facility Investigated:**

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

**Disposition:** Substantiated as to sexual abuse and neglect of a vulnerable adult by a staff person.

**License Number and Program Type:**

1003334-SUD (Substance Use Disorder)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that a staff person (SP) had a sexual relationship with a vulnerable adult (VA) while the VA received services at the facility and that the VA had naked pictures of the SP.

**Date of Incident(s):** Prior to April 15, 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 three interviews conducted with a facility management staff person (P1), a facility staff person (P2), and the VA's probation officer (PO). Although this investigator contacted the VA and the SP, the VA did not respond to requests to be interviewed and the SP declined an interview with this investigator.

The facility provided both residential and outpatient treatment services to the VA. The VA received residential services between March 20 and June 12, 2023. Beginning on June 12, 2023, the VA received outpatient treatment services until September 22, 2023.

The VA's *Comprehensive Assessment/Rule 25 and Assessment Summary* showed that the VA was "social" and "easy to get along with." In addition, the VA had a history of substance use.

P1 provided the following information:

- In November 2023, P1 received an email from the PO which stated that the VA called the PO on November 6, 2023, and asked to speak to the PO. The VA agreed to meet with the PO on November 7, 2023, but did not come in as scheduled. The PO called the VA and the VA agreed to meet the following day, November 8, 2023. When the VA talked to the PO, the VA stated that the SP had an "inappropriate relationship" with the VA. The VA stated that the SP "started to pay attention" to the VA shortly after the VA began receiving services at the facility. While the VA was in residential treatment, the SP tried to contact the VA through "Facebook," but the VA did not have access to his/her account at the time "because [s/he] was in residential treatment." The VA stated that the SP "started paying close attention to [him/her] and even offered to take [him/her] out to get something to eat on [his/her] first pass and offered to have sex with [him/her]." The VA said that on the day of the VA's first pass, s/he went with the SP in the SP's car, and they drove to a hotel a short distance from the facility. The SP brought food as s/he agreed to do and then the VA and the SP had sex for a few hours. After, the VA walked back to the facility. The VA further stated that the SP and the VA had sex "numerous times at various hotels," at the SP's "place," and at the SP's family's home. The VA stated that the "relationship" continued between June and August 2023, and that the VA had "many inappropriate text messages" from the SP. When the PO asked the VA when the VA last communicated with the SP, the VA stated within the week prior to meeting with the PO, the SP reached out to the VA and the VA told the SP to "stop contacting" the VA.
- P1 showed this investigator an email, dated November 14, 2023, in which the facility attempted to obtain direct information from the VA. The email said, "My understanding from what [the VA] reported is that the interactions described started on [the VA's] first pass from the facility which would suggest [s/he] was still in residential."
- While the VA received services at the facility, no staff person or client brought any concerns forward

related to the interactions between the SP and the VA.

Text messages and other written communication between the SP and the VA provided the following information:

- On June 3, 2023, the VA asked the SP for his/her phone number. The SP provided his/her number to the VA. The VA sent a message to the SP that said, "I miss you," and the SP responded, "I miss you too."
- On June 4, 2023, the VA asked the SP, "Wanna see me?" The SP responded, "Well ya obviously I want to. I can get this shit done then I can come get you." The SP also asked the VA to send a picture of the VA to the SP. The VA responded that s/he did not have any pictures at the time because the VA was using someone else's computer. The SP sent a picture of someone that appeared to be naked, but it was not clear who the picture was of because the person's face was not visible. Later, the SP said, "I can resend them if you want or I can just show you tomorrow." Later, the VA said, "I'll see you tomorrow love."
- On June 12, 2023 (the day the VA was discharged from residential services), the SP said, "I already miss you, like a lot," and "I'm so happy for you but seeing you packed up made me sad as hell." In addition, the VA sent pictures of his/herself to the SP. The SP also said, "I want you to fuck me so bad," and the VA said, "We're due for a few more rounds." The SP also discussed oral sex with the VA. The SP took a picture of his/herself wearing new clothes and when the VA asked what the special occasion was, the SP responded, "Seeing you tomorrow lol." The SP also said, "I don't want you to get involved with anyone else," and the VA said, "And I won't." The SP said, "You think maybe tomorrow you could find time to pull my hair again? Without anyone noticing."
- On June 14, 2023, the VA and the SP discussed sexual activities, such as the VA saying, "I really want to fuck [you right now]."
- On June 20, 2023, the SP asked the VA if s/he could introduce the VA to the SP's family and the VA said, "Not at w[o]rk tho, ya know."

The PO provided information that was similar to the information provided by P1 including that the VA and the SP had sex while the VA was receiving residential services from the facility. The VA did not provide specific dates or more information to the PO in terms of the sexual contact between the VA and the SP.

P2 stated that s/he thought that the SP had a "hard" time maintaining boundaries with some clients. P2 gave an example in which a client may tell the SP, "You're looking fine today," and when that happened, the SP did not tell that client that type of comment was "inappropriate." P2 did not know the name of the VA and did not see any interactions the SP had with clients that were of concern to P2.

Some of the SP's job responsibilities, based on his/her job description, included, "Promote and instill positive attitude and client engagement."

The facility's *Employee Handbook* stated, "Employees will deal with clients only in a professional relationship," and that "Romantic or sexual relationships between employees and clients, and clients and interns are prohibited."

The facility's training records showed that the SP was trained on the Reporting of Maltreatment of Vulnerable

Adults Act and “maintaining professional boundaries” on October 3, 2022.

**Conclusion:**

**A. Maltreatment:**

Although the VA, who received residential services from the facility between March 20 and June 12, 2023, and then outpatient services through September 22, 2023, and the SP did not respond to requests to be interviewed, the VA told the PO that s/he and the SP had sexual contact while the VA received residential services from the facility. In addition, prior to the VA’s discharge from residential services, information showed that the SP and the VA communicated through text messages that included non-therapeutic interactions, such as the VA saying, “I’ll see you tomorrow love,” and the SP asking the VA to send pictures of the VA to the SP. On the day of the VA’s discharge from residential services, June 12, 2023, the SP sent a text message to the VA saying, “I want you to fuck me so bad,” and the VA saying, “We’re due for a few more rounds.”

Given that the PO stated the VA told him/her the VA and the SP had sexual contact while the VA received residential services and that there were text messages between the VA and the SP regarding sexual contact, there was as preponderance of the evidence that the SP had sexual contact with the VA.

It was determined that 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).

In addition, given the VA’s history of substance use disorder, it was reasonable that the VA would continue to need supports to develop and maintain the necessary life and social skills to maintain sobriety. The SP’s interactions with the VA hindered the VA’s ability to have a consistent understanding of the parameters of a therapeutic relationship which could interfere with other individuals’ attempts to provide therapeutic services to the VA, both now and in the future. Therefore, there was a preponderance of the evidence that the SP failed to maintain professional boundaries and that the SP’s interactions with the VA were detrimental to the VA’s ongoing mental health and represented a failure to provide the VA with reasonable and necessary care and services.

It was determined that 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).

**B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):**

When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead agency shall consider at least the following mitigating factors:

- (1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;
- (2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

The SP was trained on the Reporting of Maltreatment of Vulnerable Adults Act and "maintaining professional boundaries" on October 3, 2022. The SP was responsible for maltreatment of the VA.

#### C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

"Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

"Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or

third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated sexual abuse for which the SP was responsible was serious maltreatment because it met the statutory definition. It was determined that the substantiated neglect for which the SP was responsible was not serious maltreatment because it did not meet the statutory definition. Neither was determined to be recurring because it was not determined how many occurrences of sexual contact there were and the neglect was considered a pattern of behavior therefore a single incident.

The SP was disqualified from providing direct contact services.

**Action Taken by Facility:**

The facility completed an *Internal Investigation* which showed that although policies and procedures were adequate, the SP “who was involved in the relationship with the participant” did not follow policies and procedures related to “vulnerable adults and reporting maltreatment” and that “no other staff [persons] were aware of the relationship until March/April 2024.” Additional training was not needed, and the SP was no longer employed by the facility.

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

The SP was disqualified from a position allowing direct contact with, or access to, persons receiving services from programs, organizations, and/or agencies that are required to have individuals complete a background study by the Department of Human Services as listed in Minnesota Statutes, section 245C.03. The determination that the SP was responsible for maltreatment and the disqualification of the SP are each subject to appeal.

The SP was regulated by a health related board so that board was notified that the SP was determined to be responsible for serious maltreatment and that the SP was disqualified.