

**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:** 202403535

**Date Issued:** July 10, 2024

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive

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

**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) showed his/her genital area to a vulnerable adult (VA); that the SP "molested" the VA; that the SP snuck a phone into the facility and allowed the VA to use it; that the SP purchased items for the VA; that the SP offered the VA \$1,000 to not say anything about the allegations; and that the SP allowed the VA to leave the facility to go shopping, but when the VA returned, the SP stated that the VA was not allowed to leave, which led to the VA being "kicked out" of the facility.

**Date of Incident(s):** Prior to April 23, 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 management staff person (P1), a facility staff person (P2), and the VA's mental health therapist (MHT). The VA did not respond to requests made for an interview. The SP declined an interview with this investigator. One additional staff person (P3) was contacted, but P3 did not respond to requests to be interviewed.

The facility provided services to the VA and other clients related to substance use disorders.

The VA's *Discharge Summary* documented that the VA received services from the facility between August 23 and October 10, 2023. The summary stated that the VA's discharge was planned and with "staff [person] approval."

The MHT and his/her written documentation provided the following information:

- On or around April 23, 2024, the VA provided limited information to the MHT. The VA stated that the SP "temporarily" took his/her clothing off and would "expose" his/her genitals to the VA while the VA received services at the facility and that the SP "molested" the VA. The VA stated that this occurred in "blind spots" where cameras were not present, but the VA did not provide additional information.
- The VA told the MHT that the SP brought a phone in for the VA to use, which was against facility policy, but the VA did not provide further information.
- The VA told the MHT that s/he purchased items for the SP and that the VA received "gifts" from the SP. The VA did not disclose what s/he received from the SP.
- The VA stated that on one unknown date, the SP allowed the VA to leave the facility and when the VA returned, the VA was told by an unknown person that the absence was not allowed, which led to the VA being discharged from the facility.
- On an unspecified date, the SP offered the VA \$1,000 to not tell anyone about the allegations, but the VA did not disclose whether s/he accepted the money from the SP. The MHT described the VA as being "clear minded" in terms of his/her ability to provide information.

P1 stated that s/he did not have knowledge of the allegations, that the VA had not brought up any concerns while the VA received services at the facility, and that no other staff person or client brought up any concerns related to the SP's interactions with the VA.

P2 stated that s/he did not have any concerns related to the VA's interactions with any staff persons, and did not have any knowledge that a staff person allowed the VA to use a phone while in the facility, or that the VA left the facility without permission.

The facility's client handbook stated, "There is no use of cell phone or other electronic devices capable of recording while in withdrawal management," but that a "phone will be available for your use between the hours of 8 a.m. and 10 p.m."

The facility's *Internal Investigation* stated, "We are unclear if this claim is true or not at this time."

The facility's training records showed that all staff persons interviewed for this investigation and the SP, were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the VA's care plans prior to April 23, 2024.

#### **Conclusion:**

On or around April 23, 2024, the VA told the MHT that the SP showed his/her genital area to the VA; "molested" the VA; snuck a phone into the facility and allowed the VA to use it; purchased items for the VA; offered the VA \$1,000 to not say anything about the allegations; and allowed the VA to leave the facility to go shopping, but when the VA returned, the SP stated that the VA was not allowed to leave the facility, which led to the VA being discharged from the facility. However, the VA did not provide additional information to the MHT, and the VA did not respond to requests to be interviewed by this investigator.

P1 and P2 did not have any information related to the allegations. The MHT described the VA as being "clear minded" in terms of providing information. The SP did not provide information for the investigation. Given that there was no information to confirm or dispute the allegations and there was very limited information regarding when the allegations occurred and the details of what occurred, there was not a preponderance of the evidence whether the SP had sexual contact with the VA or whether the SP failed to provide reasonable and necessary care and services to the VA.

It was not determined whether neglect or sexual abuse (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) occurred.

#### **Action Taken by Facility:**

The facility's *Internal Investigation* stated that although policies and procedures were adequate, it was unclear

whether they were followed by the SP. The review also noted that additional training was not needed, and that the SP was no longer employed by the facility.

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

No action taken.