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: 202402076

Date Issued: November 20, 2024

Name and Address of Facility Investigated:

Beacon Specialized Living Minnesota, Inc.
1355 Mendota Heights Road, Suite 260
Mendota Heights, MN 55120

Disposition: Substantiated as to sexual abuse of a vulnerable adult by a staff person

License Number and Program Type:

1070450-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) had sexual contact with a vulnerable adult (VA).

Date of Incident(s): March 5, 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):

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 was obtained during a site visit conducted on March 26, 2024; from documentation at the facility and a criminal complaint; and through five interviews conducted with the SP, a supervisory staff person (P1), a family member/guardian (FM) of the VA, a consumer (C) who received services from the provider, and a staff person from the VA's work program (WP). This investigator did not interview the VA because the VA already provided information to other persons including an interview with the police.

The VA's support plans stated that the VA's diagnoses included an intellectual disability. The VA received individual home support services for 24 hours each week. The VA had a limited understanding of sexual relationships and might be easily convinced to participate in activities s/he was not ready for. The VA enjoyed listening to music and participating in a wide variety of sports.

The VA lived in his/her own apartment in a large apartment complex. The provider also provided services to some individuals living in other apartments within the complex. The provider also had an apartment within the complex that was used as a staff person office.

An *Incident Report* from the VA's work program and completed by the WP stated that on March 7, 2024, the VA told the WP that on two occasions, s/he had sexual intercourse with a staff person. The VA said that one incident occurred while the person was a staff person and one incident happened after the staff person left employment. The VA did not disclose any details about where the incidents occurred or the staff person's name. The VA did say that in the first incident a condom was used and a second incident there was not a condom used. The VA also said that one incident was "accidental."

The WP provided the following additional information:

- When asked the context in which the VA brough up the allegation, the WP said that the VA was talking about a backache and that led to the allegation.

- The WP worked with the VA for several years and did not know whether the VA made sexual abuse allegations in the past, but the VA never made any allegations to the WP. The WP added that the VA was an accurate reporter of events "most of the time." The WP could not think of an example of when the VA was not accurate, but said that the VA could be "dramatic" at times.

- The WP talked with a police officer who told the WP that the VA denied to police what s/he told the WP.

P1 provided the following information in the internal review report and in an interview:

- On March 5, 2024 (a Tuesday), the SP was working with the VA from 6:30 to 10 p.m. The VA told P1 that s/he wanted to make March 5, 2024, "special" because it was the SP's last day of working with the VA. When P1 first asked the VA about the allegation on March 8, 2024, the VA said that nothing happened between the VA and the SP, but then "went back and forth" on whether the incident did happen. The VA said that the VA and the SP were "not exposed" then said that that they were "covered up." The VA said that a condom was used and then "flip flopped" on whether there was penetration. The VA said that the incident mostly involved "outside "touching, and then became frustrated and did not how to explain what happened. (P1 told this investigator that the VA indicated that incident happened in an empty bedroom in the staff person office apartment unit). The VA was worried about getting him/herself and the SP in trouble. The VA said that the

night of the incident the SP and the VA talked about getting a hotel room because the FM was going to be at the apartment that evening. P1 said that the FM spent a few nights a week at the VA's apartment.

- P1 obtained the VA's clothes s/he wore that night, and the VA went to the hospital for an examination with the FM. The FM told P1 that the hospital did not find any physical evidence of sexual contact.

- P1 spoke with the police who talked to the VA and was told that the VA gave conflicting information about the allegation to police.

- The VA was an accurate reporter of events and P1 believed what the VA told him/her. In the past, the VA had not made allegations of abuse of sexual abuse. P1 did not think the VA would make this type of an allegation without "something possibly happening."

Medical records dated March 8, 2024, stated that the VA said that three days prior, s/he had sexual contact with the SP and that there was penetration. The VA stated that s/he had pain in his/her genital area. An examination of the VA's genital area showed no signs of injury.

P1 provided the following additional information in the internal review report and in an interview:

- The staff person office was for staff persons to take breaks and do charting. An awake on call staff person stayed in the apartment overnight. The apartment had one bedroom but did not have furniture in the bedroom. Occasionally, a consumer might go to the office just to get out of their own apartment.

- The VA had an "obsession" with the SP which was consistent with the VA having obsessions with other staff persons of the SP's gender in the past.

- Months prior to March 5, 2024, the FM was concerned about texts sent from the SP to the VA as the SP said that s/he "needed [the VA] to be there for" the SP and that the SP would "be there for [the VA] forever whether [s/he was] a staff person or not." The SP told P1 that when s/he sent the texts to the VA, s/he was not in a "right state of mind" and thought s/he was sending them to a different person. There was a meeting with the SP, the VA, the FM, and P1 regarding the communication between the VA and the SP outside of working hours. After the meeting, the calling and texting "seemed to end."

- The VA usually went to bingo on Tuesday night. On the night of Tuesday March 5, 2024, at about 9:30 p.m., P1 talked to the C and the C said that the VA was not feeling well and around 7 – 7:30 p.m., the SP took the VA back to the apartment. At that time, P1 did not "think anything of it."

- The VA originally told P1 that on March 5, 2024, s/he was sick and returned to his/her apartment while the SP went to work with other consumers at the apartment. On March 6 and 7, 2024, P1 saw the VA and the VA did not say anything about the SP to P1.

- On the night of March 5, 2024, the SP did not document his/her activities with the VA. However, there were known problems with the SP getting into the computer program where times and activities were to be

documented.

- The SP told P1 that s/he did not touch the VA. The SP told P1 that after bingo on March 5, 2024, s/he got the VA something to eat and then the VA went to his/her apartment and the SP went to the office. The SP told P1 that the VA did not go up to the office. The SP did not document what s/he did with the VA. The SP also did not document about his/her interactions with the other consumers s/he worked with that day.

The C provided the following information:

- On March 5, 2024, the SP and the VA picked up the C and brought the VA to bingo. They arrived at bingo at about 6:30 p.m. The C went in to play bingo and the VA and the SP stayed in the car. At 7 p.m., the C called the SP, and the SP told the C that the SP and the VA were still outside talking in the car. The SP told the C that s/he was going back to the office to work on paperwork and that the VA did not feel good and was going to stay with the SP. The SP and the VA were going to get something to eat on the way back. At one point prior to the phone call, the C used the restroom and saw the VA leaving bingo. The C thought that the VA went in to look for the C. The C arranged to take different transportation home.

- The C had known the VA and the FM for many years. The VA usually called the C every night before s/he went to bed but did not call the C that night. Around 10 p.m., the FM texted the C and the C told the FM that s/he was at bingo, that the VA was not feeling well, and that the VA and the SP should be at the office or the apartment.

The FM stated that on the evening of March 5, 2024, the FM was at the VA's apartment. The FM heard that the SP said that the SP and the VA went back to the apartment for supper and to do laundry after bingo. However, the FM was at the VA's apartment that evening and the SP and the VA did not come to the apartment until 9:45 p.m. The VA was usually truthful and had never made allegations of sexual abuse in the past. The FM found out about the allegation on March 8, 2024, and then took the VA in for an examination. At that point, the VA had already talked to the police. Police were waiting on lab results before deciding whether to take action with the SP. The FM said that P1 and the SP were friends outside of work. (An administrative staff person [P2] confirmed that the SP used P1's address when s/he first started working for the facility).

The SP provided the following information in the internal review report:

- On March 5, 2024, the SP worked with four individuals (at different times) including the VA and the C. The SP and the VA were each present at bingo and after bingo was over, the SP dropped the VA off at the VA's apartment. The SP did not go into the VA's apartment, but "assumed" that the FM was at the VA's apartment. After the VA went to his/her apartment, the SP went to the staff person office to enter his/her documentation but did not document anything about his/her shift that day.

- Later in the interview, the SP stated that nothing happened between the VA and the SP and, "There was no bingo, and no sex." That night, the SP and the VA "hung out" between the VA's apartment and the staff person office. The SP and the VA made dinner and did laundry. The SP did not recall saying that bingo went

  on as normal earlier in the interview. The VA wanted to "hang out" with the SP because it was the SP's last day of work.

- The SP was aware that the VA had a "crush" on him/her. On an earlier date during his/her employment, the SP had a fight with his/her "ex" and then texted the VA after working hours that s/he "missed" the VA. The SP said s/he needed someone to talk to and understood how the text could have been "misinterpreted" by the VA. The SP thought of the VA like a family member. After the incident with the text, a meeting with set up with the SP, the VA, P1, and the FM; and the SP never texted the VA outside of working hours again.

- The SP said that the VA and the SP never touched each other, that the VA never attempted to engage in sexual activities with the SP, and that the SP never tried to engage in sexual activities with the VA.

The SP provided the following information in an interview with this investigator:

- March 5, 2024, was the SP's last day at work. The SP worked with several individuals. The SP worked with the VA from 7 – 9:30 p.m. The SP and the VA watched television and made a stir fry dinner. The SP and the VA went to the staff person office for about an hour, worked on math problems, and watched videos then the SP brought the VA back down to his/her apartment. The FM stayed at the apartment on Tuesday nights and the VA wanted to be back by 9:30 because the FM slept on the couch. The SP did not walk the VA to the apartment door but believed that the FM was there because the FM's vehicle was in the parking lot when the SP left.

- The SP dropped off the C at bingo that evening. After dropping the C off, the SP returned and saw the VA. The VA did not go with the SP when the SP dropped the C off at bingo.

- The SP did not have physical or sexual contact with the VA. The SP did not know why someone would say that s/he did. The SP said that the VA was getting a "little obsessive" and "clingy" with the SP. When the SP talked with the VA about leaving his/her job, the VA would become "quiet." The VA told the SP that if s/he got "fired" that the SP and the VA might be able to be together on a "personal level." The SP met with the FM and P1 regarding some of the concerns with the SP and the VA.

The facility's *Professional Boundaries* policy stated that if staff persons were not "on the clock," staff persons were not to engage in any communication with consumers. Staff persons were not to share any personal information with consumers. Staff persons were not to have sexual contact with consumers.

Facility documentation showed that P1 and the SP each received training on the VA's support plans, professional boundaries, and on the Reporting of Maltreatment of Vulnerable Adults Act.

A criminal complaint filed on November 1, 2024, included the following information:

- The VA told law enforcement that on March 5, 2024, the SP and the VA dropped off "a friend" at bingo, returned to the facility, and had penetrative sexual intercourse in the staff office unit.

- The clothing the VA wore on March 5, 2024, was collected and bodily fluids were found in the VA's underwear. DNA testing confirmed that the DNA profile of the bodily fluids matched the SP's DNA profile.
- The SP was charged with criminal sexual conduct in the third degree.

Conclusion:

A. Maltreatment:

On March 7, 2024, the VA told the WP that on two occasions, s/he had sexual intercourse with a staff person. The VA said that one incident occurred while the person was a staff person and one incident happened after the staff person left employment. The VA did not disclose any details about where the incidents occurred or the staff person's name. The VA did say that in the first incident a condom was used and a second incident there was not a condom used. The VA also said that one incident was "accidental."

The criminal complaint showed that the VA told law enforcement that on March 5, 2024, s/he and the SP dropped off "a friend" (most likely the C) at bingo, returned to the facility, and had penetrative sexual intercourse in the staff office unit. Information from the C, the FM and P1 was consistent that on the evening of March 5, 2024, the SP worked with the VA and there were no witnesses to their whereabouts or conduct from about 7 to 9:45 p.m.

The SP denied that the s/he had sexual contact with the VA. However, the criminal complaint showed that the SP's bodily fluids were found in underwear that the VA wore on the evening of March 5, 2024, and the SP was charged with third degree criminal sexual conduct in relation to the incident. Therefore, there was a preponderance of the evidence that the SP had sexual contact with the VA on March 5, 2024.

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).

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:
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> (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;
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> (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 received training on the VA's support plans, professional boundaries, and on the Reporting of Maltreatment of Vulnerable Adults Act, prior to the incident. 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 abuse for which the SP was responsible was serious maltreatment because the SP sexually abused the VA.

Action Taken by Facility:

The facility completed an internal review and determined that their policies and procedures were adequate but were not followed. The SP no longer worked at the facility.

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

The SP was notified that s/he was responsible for serious maltreatment and that any future background studies for facilities, 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, will result in his/her disqualification. The determination that the SP was responsible for maltreatment is subject to appeal.