

**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:** 202409184

**Date Issued:** June 6, 2025

**Name and Address of Facility Investigated:**

**Disposition:** Substantiated as to neglect of two vulnerable adults by the facility.

Oakridge Homes SILS, Inc LP #4  
817 3rd Ave SE  
Long Prairie, MN 56347

Oakridge Homes SILS Inc  
1021 Industrial Park Rd SW  
Brainerd, MN 56401

**License Number and Program Type:**

1075657-H\_CRS (Home and Community-Based Services-Community Residential Setting)  
1067880-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that two vulnerable adults (VA1 and VA2) were not supervised and engaged in sexual contact with one another.

**Date of Incident(s):** October 21, 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 17, paragraph (a):**

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 November 5, 2024; from documentation at the facility; and through twelve interviews conducted with VA1, VA2, two supervisory staff persons (P1 and P2), a facility staff person (SP), VA1's guardian (G1), VA2's guardian (G2), three staff persons at VA1's and VA2's day program (D1, D2, and D3), VA1's and VA2's case manager (CM), and a mental health professional for VA2 (MHP).

The facility was a rambler style home with a full basement. On the main level there was a kitchen, a dining room, a living room, two bedrooms, and two bathrooms. In the basement, there were two bedrooms (VA1's and VA2's), a bathroom, and an open area with a desk for crafts. VA1's permanent bedroom door had a lock. At the time of the incident, VA1's permanent bedroom was undergoing construction from a water leak, so VA1 was using a temporary bedroom just outside of his/her permanent bedroom in the open area. The temporary bedroom was enclosed by two by fours and plywood. P1 stated there was a door to the temporary bedroom, but according to VA1, VA2, and the CM there was a cloth draping the entry to the room, not a door.

There were two cameras in the basement, one near the bathroom facing VA1's and VA2's bedroom doors, and one near VA1's bedroom door. There was a monitor (a little larger than a cell phone) that staff persons carried with them that displayed the camera feed. The monitor could only display one camera view at a time, so both camera views could not be monitored simultaneously.

VA1 was diagnosed with a mild developmental delay and enjoyed drawing, painting, and sewing. VA1's *Support Plan (SP)* showed that the facility had 24-hour awake overnight shift staff persons to supervise VA1. VA1's *Support Plan Addendum (SPA)* showed that monitoring technology was used to reduce or minimize critical incidents. The facility installed multiple video cameras in common areas in the facility both on the main level and the basement, so that staff persons could safely monitor VA1's interactions with his/her housemates. VA1's *Individual Abuse Prevention Plan (IAPP)* showed VA1 was susceptible to sexual abuse and that facility staff persons supervised VA1 when s/he was downstairs in the facility with other housemates by using a video camera system. VA1's support plans did not further specify how VA1 was supervised when s/he was downstairs at the facility with housemates. VA1's *Self-Management Assessment (SMA)* was marked that VA1 independently self-managed a bedroom door lock.

VA2 was diagnosed with a mild developmental delay and a psychosexual disorder. VA2 enjoyed cooking, bowling, and watching movies. VA2's *Support Plan (SP)* showed that VA2 received 24-hour supervision at the facility. VA2's *Support Plan Addendum (SPA)* showed that VA2 had a history of engaging in maladaptive sexual behaviors with children and other vulnerable adults. The facility installed multiple video cameras in common areas in the facility both on the main level and the basement, so that staff persons could safely monitor VA2's interactions with his/her housemates. VA2's *Individual Abuse Prevention Plan (IAPP)* showed that VA2 was susceptible to sexual abuse and that facility staff persons were aware of VA2's maladaptive sexual behaviors and directed VA2 from any activity that could increase VA2's risk of engaging in this type of behavior. VA2's support plans did not further specify how VA2 was supervised when s/he was with housemates.

An *Incident and/or Behavior Report* for VA2 showed that on October 21, 2024, VA2 walked into a housemate's bedroom naked (there was no name, but likely VA1's temporary bedroom). VA2 stood in front of the housemate with his/her genitalia in the other housemate's face while rubbing that housemate's shoulders, back, and leg areas while attempting to hug the housemate. The housemate asked VA2 to leave and it was unknown the length of time VA2 was in the other housemate's bedroom.

VA2 provided the following information:

- VA2 did not remember the date of the incident but stated that VA1 was in a temporary bedroom and VA1 only had something "like a robe" covering his/her door. Around 9:15 p.m., VA2 had a "strong" feeling and went to VA1's temporary bedroom and found VA1 in a chair with just a shirt on. At the time VA2 had no clothes on. VA2 went over and hugged VA1 for four to five seconds and touched VA1's shoulder.
- VA1 said, "[VA2] you might get caught," to which VA2 responded, "We won't get caught because the camera does not work." VA1 got up to look for something, VA2 walked behind VA1, and VA2's genitalia "might have" touched VA1's buttocks. VA2 stated that s/he was "kind of" aroused when that happened. Otherwise, VA2 did not touch VA1's legs or genitalia. VA1 did not touch VA2.
- VA1 did not say anything to VA2 during the interaction but laughed. VA2 told VA1 that VA1 could go to VA2's bedroom if VA1 wanted to. VA2 left at that time and went back to his/her bedroom. VA2 thought s/he was in VA1's bedroom for two to three minutes.
- VA1's normal bedroom had a lock on it and VA1 kept it locked because s/he did not trust VA2. VA2 said there were two cameras downstairs, but only one worked and that staff persons upstairs used a monitor to watch what was happening downstairs. VA2 told P1 that the cameras were not working, and P1 told VA2 that s/he trusted VA2 "Not to do anything stupid down there."

VA1 provided the following information:

- On an unknown date, VA1 was watching television in his/her chair in his/her "cubby cage" (this was how VA1 described his/her temporary bedroom) late at night. VA2 walked in through a robe hanging up and VA2 touched VA1 "all over" (VA1 motioned to his/her stomach when s/he said this).
- VA1 did not touch VA2, but VA2's genitalia touched VA1's genitalia and VA2 was "kind of" aroused. VA1 told VA2 to get out of his/her bedroom. VA2 was in VA1's bedroom for "quite a while." VA1 said s/he went upstairs after VA2 left and VA1 told an "overnight" staff person (VA1 did not remember the staff person's name) what happened.
- VA1's permanent bedroom before had a lock on it, but the temporary bedroom did not. VA1 said the cameras downstairs were for VA2, not for VA1. VA1 was "scared" of VA2.

D1, D2, and D3 provided the following information:

- On October 22, 2024, VA1 provided consistent information to D1, D2, and D3 that on October 21, 2024, VA2 went into VA1's bedroom naked and touched VA1 "all over." VA1's bedroom was being redone so

VA1 was in a "cubby." VA1 was watching television in his/her chair with just a shirt on when VA2 came in with no clothes on and touched VA1 (VA1 made a motion to D1 using both hands all over the front of VA1's body), including VA1's chest and genitalia. VA1 said s/he did not touch VA2 back. VA1 did not tell VA2 to stop or yell for staff persons because VA1 was "too scared."

- VA1 said after the incident, VA2 went back to his/her bedroom. In the morning after VA2 left the facility, VA1 told an unidentified staff person at the facility what happened and VA1 was told they would "take care of it." VA1 did not feel safe.
- VA1 also told D2 and D3 that during the incident, VA2 told VA1 s/he could go back to VA2's bedroom if VA1 wanted to. VA1 said they would get in trouble and VA2 said the cameras did not work.
- D2 and D3 also talked with VA2 about what happened on October 21, 2024. D2 said VA2 denied what happened for about 15 minutes, and then VA2 "broke down" and said, "I am being set up to fail." VA2 said the cameras in the basement were not working, and when VA1 had his/her own bedroom s/he was able to lock it. VA2 told D2 and D3 that on the day of the incident, s/he woke up around midnight and VA1's television was on, so VA2 went wearing just his/her robe to tell VA1 to turn the television down. VA1 was sitting in a chair with just a t-shirt on, and VA2 rubbed VA1's shoulders. VA1 had a cup, and it tipped over spilling what was inside, so VA1 got out of the chair, bent over, and picked up the cup. VA1's buttocks rubbed against VA2's genitalia when this happened. VA2 then told VA1 that they could go to VA2's bedroom, and VA1 said they would get caught. VA2 told VA1 the cameras did not work. VA2 went back to his/her bedroom, waited 30 minutes for VA1 to show up at his/her bedroom and when VA1 did not, VA2 masturbated and went to sleep.
- D2 brought VA2 back to the facility on the afternoon of October 22, 2024, and spoke with P2. D2 asked P2 if the cameras were working and P2 said s/he would check. Later that day, P2 told the CM that both cameras were working. After the CM went out to the facility, P1 heard from the CM that only one camera was working, and it was pointed at a mirror. D2 said P2 then "changed" his/her account, stating that VA2 had unplugged one of the cameras.
- D2 and D3 said VA1 was a reliable reporter of events. VA1 "stewed" on the incident all day, but when s/he spoke with D2 and D3, VA1 was in tears. D2 said when VA1 said s/he did not feel safe it was because s/he loved VA2 and would not have been able to say, "No" to VA2. D3 said VA1 would have been an active participant in the incident.
- D2 and D3 said that even though VA2 denied the incident happened in the beginning, ultimately VA2 told them what happened, and it was consistent with what VA1 told them.

P1 and P2 provided the following information:

- P1 said that on an unknown Monday (note: October 21, 2024, was a Monday), the SP called P1 and told P1 that VA1 told the SP that VA2 entered VA1's bedroom and VA1 and VA2 "crossed a line" by not respecting personal space and boundaries. VA1 was "upset" about what happened. P1 then reached out to P2 to let P2 know what happened.

- P2 said that the SP worked the awake overnight shift and on October 22, 2024, around 9 a.m., VA1 told the SP that VA2 had come into VA1's bedroom naked and VA2 petted VA1's arm and leg. VA2 then propositioned VA1. VA1 declined and told VA2 to leave VA1's bedroom, which VA2 did. VA2 was in VA1's bedroom for an undetermined amount of time. P2 said the cameras were working at the time of the incident.
- P1 said that VA1 and VA2 had 24-hour supervision in their plans and there was one awake overnight staff person for the whole house (this included VA1, VA2, and two other residents whose bedrooms were on the main level). P2 said there were measures in place to prevent something happening between VA1 and VA2 since an incident had occurred previously before P1 worked at the facility. P1 said there were cameras in place for monitoring, and VA1 and VA2 were not allowed to be downstairs alone together.
- P1 said when it was time for VA1 and VA2 to go to bed, VA1 went downstairs 30 minutes prior to VA2 to go to the bathroom, change into his/her pajamas, and then go to his/her bedroom and lock the door before VA2 arrived downstairs. P1 said most staff persons did not go downstairs unless there was an emergency because VA1 and VA2 were light sleepers.
- P1 stated that sometimes VA2 unplugged the cameras when staff persons were not looking and at the time of the incident only one camera was working, but it had a whole view of the basement and staff persons were able to see a live view on the monitor. About a week before the incident, VA2 told P1 that one camera was not working. P1 submitted a request to fix the camera, but did not feel it needed "immediate" attention as the other camera still worked.
- When VA2 told P1 that a camera was not working, P1 told VA2 that s/he trusted VA2, and that the other camera provided a full view of the basement. P1 told VA2 to, "Mind his/her bobber," a phrase staff persons commonly used to remind VA2 to focus on him/herself.

The SP provided the following information:

- On an unspecified date, the SP began his/her overnight shift around 9 p.m., and both VA1 and VA2 were awake. VA1 went downstairs first and 30 minutes later VA2 went downstairs. The SP stated the overnight went "fine." The next morning VA1 told the SP that VA2 entered VA1's temporary bedroom naked, went into VA1's space, and called VA1 "cute." VA1 was really "sad and upset" about what happened. The SP called P1 and wrote up an incident report about what happened.
- There were four cameras in the house, two upstairs and two downstairs. One of the cameras faced VA1's and VA2's bedroom doors and typically the SP was able to see where VA1 and/or VA2 were on the monitor while the SP worked upstairs (folding laundry, counting money, assisting the clients upstairs, etc.)
- On the day of the incident, it was more difficult to supervise the basement using the cameras because VA1's temporary bedroom blocked some of the basement in the camera view, and it was "kind of hard to see things." The SP stated P1 and the facility were aware of this issue. The SP was not told that VA1 had been moved into the temporary bedroom, s/he found out on his/her own.
- VA1 had a lock on his/her permanent bedroom door, but the temporary bedroom was like a "big box"

right outside of his/her permanent bedroom. The SP stated it had a door, but no lock on it. VA2 waited for "opportunities" and watched staff persons watch the cameras.

- The SP had the camera monitor with him/her at all times on the evening of October 21-22, 2024, but did not see VA2 enter VA1's temporary bedroom. The SP thought it might have happened when s/he assisted another client and therefore could not maintain constant focus on the monitor. The SP did not hear VA1 call out. The SP stated there was no time that the cameras were not working when the SP was at the facility.

The CM worked with both VA1 and VA2. VA1 and VA2 had an incident in the past and that was why there was a lock on VA1's bedroom door and why the cameras were set up. Per the facility's *Incident and/or Behavior Report* the CM was notified of the incident on October 22, 2024, at 5:02 p.m. The CM was told by P2 that the cameras were working. The CM went to the facility the same week s/he learned of the incident and found the cameras sent video feed to a monitor and only one camera in the basement was working. The working camera was propped up and pointed at a mirror. The CM did not go downstairs but reviewed what staff persons saw on the live feed from the baby monitor they were to hold and watch. The CM spoke with VA2 when s/he visited the facility and VA2 told the CM that the cameras had not been working and VA2 did not feel that the staff persons protected VA2 like they should have and that VA2 was "very nervous and uncomfortable." The CM was "never" called about VA1 being moved into a temporary bedroom in the basement living room with a sheet for a door. The CM did not think the staff persons were watching the monitoring system.

G1 received a telephone call from P2 notifying him/her of the incident, but had not received any written report about what had happened, which was what G1 "normally" received. G1 spoke with VA1, and s/he seemed "okay." G1 stated that VA1's bedroom was in the basement and G1 had no knowledge that VA1 was in a temporary bedroom due to construction in VA1's bedroom. G1 stated there were cameras set up so that staff persons could watch downstairs. G1 said VA1 was "always" truthful but might be a little afraid to talk and share.

G2 received a phone call on October 23, 2024, from a representative from the facility and was told that an incident happened on October 21, 2024. G2 was told that after VA2 had gone to bed, s/he was awoken by another housemate's (likely VA1's) television being too loud. VA2 went to see what was going on and proceeded to "expose" him/herself to the other housemate, but G2 was told that no contact occurred. G2 stated it was "troublesome" that the other housemate's bedroom was under construction so there was no door to his/her bedroom and the extent of the bedroom was a sheet across a couple of two by fours. VA2 had complained to G2 for months prior to the incident that the cameras in the basement were not functional and were not being monitored. VA2 had complained to staff persons at the facility and the facility's response was they trusted VA2 to mind his/her own business. G2 stated that there had been "violations" between VA1 and VA2 previously and to put VA2 in an "advantageous" situation was unacceptable.

The MHP said VA2 expressed concerns about a lot of things. VA2 looked for things that were not taken care of in the facility and VA2 "seemed" to take advantage of "loopholes" s/he could exploit. The MHP gave an example of VA2 complaining of not being tightly monitored, but then waiting to take advantage of when it occurred.

The facility's *Program Abuse Prevention Plan (PAPP)* stated that the basement was difficult to supervise, and cameras had been installed to allow staff persons to safely monitor client interactions, due to a client having a history of sexually offending against other vulnerable adults. Each bedroom had a locking door handle.

The facility's *Internal Review* stated, "Although supervision requirements were followed, the current camera system is not adequate. It is also not reasonable for staff [persons] to stare non-stop at this camera feed, particularly when they need to be assisting other [clients]."

Facility records showed that P1 and the SP were each trained on VA1's and VA2's plans, the *PAPP*, and the Reporting of Maltreatment of Vulnerable Adults Act.

Law enforcement responded to the incident, but there were no criminal charges filed.

### Conclusion:

#### A. Maltreatment:

Information was consistent that VA2 had a history of engaging in maladaptive sexual behaviors with other vulnerable adults, VA1 was susceptible to sexual abuse, and staff persons were to monitor VA1's and VA2's interactions when they were downstairs via video cameras that displayed live feed on hand held monitors. According to VA2, VA1 usually locked his/her bedroom door because s/he did not trust VA2. However, on October 21, 2024, VA1 was using a temporary bedroom that did not have a locking door.

Consistent information was provided that on the night of October 21, 2024, VA1 was in his/her temporary bedroom watching television wearing only a shirt when VA2 entered the temporary bedroom naked. VA2 said s/he hugged VA1 and touched VA1's shoulder, and when VA1 stood up, VA2's genitalia "might have" touched VA1's buttocks. VA1 said that VA2 touched VA1 all over (and motioned to his/her stomach) and that VA2's genitalia touched VA1's genitalia. VA2 told VA1 that they could go back to VA2's bedroom and would not get caught because the cameras were not working. VA2 left VA1's temporary bedroom and went back to his/her bedroom. VA1 did not follow.

The next morning VA1 told the SP what happened, the SP notified P1, and D1, D2, and/or D3 later spoke with VA1 and VA2 about the incident. The SP said s/he had the camera monitor with him/her at all times during the night of October 21-22, 2024, and s/he did not see VA2 enter VA1's bedroom, but thought it might have happened when the SP was looking away from the monitor to assist another client upstairs. There were concerns about the cameras not working on the day of the incident but due to conflicting information, it could not be determined whether the cameras were working at the time of the incident. However, even if the cameras were working, the facility determined in its *Internal Review* that the camera system in use at the time of the incident was "not adequate" and that it was "not reasonable" for staff persons to watch the live camera feed constantly.

Given that VA1 did not have access to a locking door on the date of the incident, that the facility's plan to supervise VA1 and VA2 via live camera feed did not sufficiently mitigate the risk of unsupervised contact between VA1 and VA2, and that VA2 was able to enter VA1's temporary bedroom and had sexual contact with VA1, there was a preponderance of the evidence that there was a failure to supply VA1 and VA2 with supervision that was reasonable and necessary to maintain their physical or mental health or safety.

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 responsible for the supervision of VA1 and VA2 at the time of the incident. However, the SP said s/he followed the policies the facility had in place, such as carrying the hand held monitor with him/her at all times and having VA1 and VA2 go to the basement to get ready for bed at the established 30-minute interval. In addition, the facility determined in its *Internal Review* that the camera system in use at the time of the incident was "not adequate" and that it was "not reasonable" to expect staff persons to constantly watch the live camera feed on the handheld monitor. Therefore, the SP's responsibility was mitigated, and the facility was determined responsible for the maltreatment of VA1 and VA2.

C. Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by a facility meets the statutory criteria to be determined as "serious."

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 neglect for which the facility was responsible did not meet statutory criteria to be determined as serious as neither VA1 nor VA2 was physically injured, and there were no criminal charges filed in relation to the incident.

**Action Taken by Facility:**

The facility completed an *Internal Review* and found their policies and procedures adequate and followed. The facility planned to install a better camera system and installed a hard-wired an alarm system on VA2's bedroom door which alerted staff persons upstairs when VA2 entered or exited his/her bedroom.

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

On June 6, 2025, the license holder was ordered to forfeit a fine of \$1,000 as a result of the substantiated maltreatment for which facility was responsible. The maltreatment determination and the Order to Forfeit a Fine are each subject to appeal.