

MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 260E.01, paragraph (a), "The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment."

Report Number: 202400211

Date Issued: June 18, 2025

Name and Address of Facility Investigated:

Anthony Louis Center North
1000 Paul Parkway
Blaine, MN 55434

Disposition:

Maltreatment determined as to neglect of alleged victims by two staff persons.

License Number and Program Type:

1038850-CRF (Children's Residential Facility)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that two alleged victims (AV1 and AV4) left the facility because staff persons (SP1 and/or SP2) yelled at them; AV1 returned but AV4 did not. It was also reported that SP1 and SP2, who maintained contact with AV1 from an earlier placement at the facility, had boundary issues with residents including that SP1 and/or SP2 had taken residents to their home, out for fast food, provided them with cigarettes, showed them nude photos of staff persons, and drank alcohol while driving with residents in the vehicle.

Date of Incident(s): Various Dates

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2):

Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so.

Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health

when reasonably able to do so.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on January 19, 2024; from documentation at the facility, law enforcement records; and through 12 interviews conducted with facility staff persons (P1, P2, and P3), SP1 and SP2, AV1, two other alleged victims (AV2 and AV3), and four guardians (G1-4) of AV1-4 respectively. This investigator was unable to contact AV4. According to G4, guardian for AV4, at the time that this report was made and through the present date, AV4's location was unknown. G1, G2, and G4 did not provide any information regarding the allegations in the report.

The facility provided teen-aged youth with residential treatment services for individuals struggling with chemical use, behavioral issues, legal problems, and educational problems. The facility had two levels. The main level consisted of staff offices, resident bedrooms, a group therapy room, and bathrooms. The lower level consisted of a kitchen, a dining room, additional bedrooms, bathrooms, and staff offices.

AV1 was diagnosed with opioid use disorder and asthma. AV1 was a residential client of the facility on two separate occasions: first from March 19 through July 13, 2023, and again from November 13, 2023, through February 15, 2024. AV1 had a goal to remain sober.

AV2 received services from the facility for opioid use disorder. AV2 was a residential client of the facility on two separate occasions: first from April 24 through August 19, 2023, and again from October 23, 2023, through January 12, 2024. AV2 liked to play video games and wanted to take up welding after school.

AV3 received services from the facility for substance use disorder. AV3 was a participant in the facility's program from November 17, 2022, through July 19, 2023. Throughout AV3's participation in the facility's program, AV3 was an inpatient and outpatient client. AV3 liked art, painting, and making jewelry, had set a goal to develop a sober support network.

AV4 received services from the facility for substance use disorder. AV4 had a goal to acquire coping skills for long-term sobriety. AV4 was a residential client of the facility from November 23, 2023, until AV4 left the facility on January 6, 2024. AV4 also left the facility on January 4, 2024. According to LE records, the facility notified LE and AV4 was found at a nearby parking lot and then returned to the facility.

SP1 worked at the facility from April 29, 2022, through January 10, 2024; SP2 worked at the facility from July 5, 2022, through January 9, 2024.

The facility's *Personal Relationships with Clients* policy stated that "employees shall not engage in personal relationships or sexual contact with clients during their tenure within the program for a period of two years from the client's date of discharge."

The *Safe Transportation* policy stated that no "client will be transported by anyone under the influence of any chemical which may impair their driving abilities." The *Smoking* policy stated that "smoking is not allowed during transportation in any vehicles."

The facility provided some screenshots of messages exchanged between SP1, SP2, and AV3 from January 2-8, 2024, screenshots of messages of a sexual innuendo shared with AV3 and messages between AV3 and SP2 about

AV3 having left her/his vape at SP2's house, after VA3 had been discharged from the program. The facility also provided screenshots from its security system from January 5, 2024. Law enforcement (LE) was able to obtain additional screenshots of photos that were alleged to have been shared with AV1 and AV2 by SP1 and SP2. The facility had an unwritten practice of not allowing residents to have access to social media.

AV1 provided the following information:

- AV1 became close friends with SP1 after the first time that AV1 was discharged from the facility. SP1 and SP2 visited her/him over the summer of 2023 after the first time AV1 was discharged from the program. SP1 had a cabin in the area and offered to come and visit AV1. AV1 stated that s/he advised a parent that s/he was going out but did not say with who; AV1, SP1, and SP2 drove around and went to Starbucks.
- On an unspecified date (because AV1 did not know the dates, it was not determined whether this occurred while AV1 received facility services), AV1 used SP1's phone and saw a photo of SP2 and then SP1 showed AV1 a photo of SP2 showing SP2's bare back and buttocks with a large tattoo on SP2's back. AV1 stated that s/he was shown a video from SP2's Snapchat story in which SP1's head was between SP2's breasts. AV1 also stated that s/he received a Snapchat video from SP2 of a conversation between SP1 and SP2 in which they appeared to be naked and in bed, the conversation was a reference to oral sex.
- On December 31, 2023; SP1 and SP2 went to the facility and took AV1, and other residents out of the facility and "chilled" in a car and then went to McDonald's. SP1 drove SP2's car; AV1 believed that SP2 had been drinking because AV1 smelled alcohol on SP2 when they hugged.
- On January 4, 2024, AV1 went into the facility office during the late hours of the evening and met with SP1 and SP2. During that time, AV1 stated that s/he was allowed to access social media; AV1 did not say whether it was on a facility computer or someone's personal device.
- On January 6, 2024, AV1 needed hygiene products and under the pretext of going to the store to purchase such products SP2 took AV1 out of the facility and went to SP2's house, where they ate and smoked cigarettes. AV1 said that SP2 drank alcohol before SP2 drove AV1 back to the facility. AV1 noted that SP2 drank alcohol with another client, AV3 on an unspecified date (AV1 did not provide further details). AV1 stated that s/he posted a photo on social media featuring AV1 smoking a cigarette with SP2 accompanied by the caption, "Smoking a cigarette with my treatment counselor is crazy."
- On an unspecified date, AV1 called SP2 from an unspecified staff person's phone and SP1 answered the phone. AV1 heard SP2 say in the background, "Fuck that snake bitch." AV1 stated that SP1 told her/him to get a pass for the weekend of January 13, 2024, and run from the facility.
- AV1 stated that SP2 gave her/him cigarettes but never alcohol or other substances like marijuana. According to AV1, SP1 and SP2 were in a relationship, and they would talk to the residents about their relationship.
- AV1 did not provide information regarding being yelled at by either SP1 or SP2.

AV2 provided the following information:

- On December 31, 2023, SP1 and SP2 picked up AV1, AV2, and AV4 at the facility. SP1 entered the facility and SP2 waited outside and gave them all a hug and cigarettes. SP2 drank in the car. They went to McDonalds and then to a park near the facility where they smoked cigarettes provided by SP2 and took pictures. They were gone from the facility for about 30 minutes.
- On an unspecified date, after December 31, 2023, SP1 and SP2 were messaging AV2 telling her/him not to trust anyone at the facility, not to return to the facility from her/his weekend pass, not to tell AV2's probation officer that they were messaging with each other because they would get in trouble.
- AV2 stated that s/he had been sent photos of SP1 and SP2 kissing and was shown a photo by SP1 of SP2 either on a boat or beach with SP2's hands covering her/his breasts and another photo of SP2 where SP2 was naked arching her/his back, but the photo did not show any genitals or nipples. AV2 also stated that SP1 and SP2 would talk about having sex.
- AV2 stated that either SP1 or SP2 would push back AV2's urinalysis so that, if s/he wanted to, AV2 could drink or use controlled substances. AV2 stated that s/he had never been to SP1 or SP2's home and that December 31, 2023, was the first time that s/he left the facility with SP1 and SP2, but that AV3 would visit their home. AV3 would "babysit" for them while AV3 "was getting treatment."

AV3 provided the following information:

- AV3 stated that s/he never visited SP2's house while s/he was receiving services from the facility but did afterwards; AV3 was friends with SP2's child and family member.
- AV3 stated that s/he would go on group outings with SP1 and/or SP2; they would go bowling and sometimes to McDonalds but never on individual outings; like those with AV1-2 and AV4. AV3 never saw SP1 and/or SP2 smoke but believed that SP1 was a smoker. AV3 stated that s/he did vape in January 2024 but quit around February 2024. AV3 never witnessed SP1 or SP2 drink alcoholic beverages.
- Regarding a Facebook message to SP2 asking about AV3's vape, which was posted on January 2, 2024, AV3 stated that s/he was messaging with SP2's family member because s/he would never ask that of SP2. AV3 further noted that SP2's family member was grounded from her/his social media, so the family member was likely using SP2's phone. Regarding messages about P1 attempting to contact AV3's guardian, and the suggestion to block P1's number and SP1's or SP2's office number, AV3 again stated that s/he was probably talking to SP2's family member.
- Regarding messages posted on January 8, 2024, about having P1 and the facility's number blocked and AV3's parents being on her/his side; AV3 stated that s/he was messaging with SP2's family member, who was using SP2's account.
- AV3 had no knowledge of SP1 or SP2 showing nude pictures to any resident at the facility. Neither SP1 nor SP2 ever encouraged residents to leave the facility.

G3 stated that AV3 spent a lot of time at SP2's home, "has been hanging over there for a couple of years or a year." AV3 left the program in July of 2023, AV3 did a lot of babysitting and it was a healthy environment for AV3;

at SP2's house. Prior to learning of the report, G3 had no concerns about SP1 or SP2.

SP1 provided the following information:

- SP1 last worked at the facility on the evening of January 4, 2024, overnight. Sometime after that evening SP1 got a call from P2 to discuss bed checks during that overnight shift; SP1 admitted that s/he had not done the 15-minute bed checks because in past practice, it was acceptable to check cameras in lieu of conducting bed checks. SP1 stated that P2 said s/he had to physically check. SP1 recalled that AV1 was in the office sometime between the hours of 12 and 3 a.m.
- SP1 was aware of a facility policy regarding contact with clients after they left the program, however, SP1's understanding of that policy was that it pertained to sexual contact, not communication with former clients. SP1 stated that AV1 had contacted her/him toward the end of summer 2023 because AV1 had relapsed. SP1 informed P2 about it, who said it was okay before saying it was not. SP1 was friends with AV1 on social media.
- SP1 denied ever taking any clients to her/his residence, providing them with cigarettes or alcohol, drinking alcohol while driving clients, yelling at or encouraging them to leave the facility. SP1 denied any knowledge of any residents seeing nude photos of SP1 or SP2. SP1 also denied ever being in a relationship with SP2 or living with SP2.
- SP1 admitted to visiting AV1 in Bemidji during the summer of 2023, they spent about 45 minutes together at a lake near AV1's home. During that visit, AV1 had a cigarette, but it was not given to AV1 by SP1.
- SP1 denied ever taking any resident to McDonalds. SP1 stated that on December 31, 2023, SP1 went to the facility, alone, to check on staff persons because the facility was short staffed and then went about with her/his plans. SP1 acknowledged that there was a policy for new residents restricting weekend passes for their first 30 days but that it was not strictly followed because many exceptions were made for residents.

SP1 provided the following information to LE:

- SP1 went to the facility on December 31, 2023, around 8:30 p.m. and was only there for 10 minutes; SP2 was not with her/him. SP1 admitted that s/he did see AV1, AV2, and AV4 at the facility that night. SP1 was alone and did not see SP2 that night until later in the evening; around 11 p.m.
- SP1 never saw SP2 give any resident cigarettes or anything like that. SP1 stated that s/he did not know anything about AV3's message regarding a vape. SP1 also stated that s/he did purchase hygiene products for AV1 but never took AV1 out of the facility to do so.
- Regarding the pictures seen by AV1 on SP1's phone, AV1 stated that the person in the picture was not SP2 but was of an ex-partner; the picture was on SP1's home screen. SP1 would let the residents pick music on her/his phone to listen to in the morning during breakfast, that was when AV1 saw that picture. AV1 grabbed her/his phone and swiped out of the music [app] and that picture was there. SP1 stated that SP2 has tattoos on her/his back but that picture was not SP2.

- Regarding the visit with AV1, SP1 stated s/he only went once to visit AV1. SP1 admitted to messaging with AV1 on Snapchat. They often talked when AV1 was struggling.

SP2 provided the following information:

- SP2 was a director at the facility and filled in at another facility that also served juveniles. SP2 was familiar with the facilities policies and practices including conducting 15-minute bed checks at night.
- SP2 stated that it was facility practice that after a client's first 30 days, clients would be eligible for a pass to go on outings. SP2 did not recall there being a policy that staff persons could not have contact with clients after they left the program, other than a prohibition on sexual contact with clients, while clients were at and after leaving the program. All outings had to be approved by either SP2 or P2, but P2 then stated that only P2 could approve outings.
- SP2 stated that s/he did not believe there was a policy that addressed taking clients to a staff person's home but did recall that P2 had given permission to a facility nurse to take clients to her/his home to get a couch that was donated to the facility.
- SP2 stated that s/he was at the facility on December 31, 2023, when several clients were allegedly taken to a McDonalds. SP2 had brought food from McDonalds back to the facility but never took clients there. SP2 recalled taking clients to appointments and missing a meal because of that, so s/he would stop somewhere and get something for the client to eat.
- SP2 denied ever taking clients out in her/his car and smoking or drinking in the car while with clients. SP2 also denied ever giving clients cigarettes or marijuana. Staff persons were not allowed to bring cigarettes or vapes into the facility, they had to do that in their cars while on break.
- On January 4, 2024, SP2 went home around 8 p.m. after working his/her regular shift, had dinner and returned to the facility shortly after 10 p.m. to conduct a COVID-19 cleaning due to an outbreak at the facility and remained there till about 2 a.m. SP2 later clarified that s/he was tired afterwards and went into P1's office around 2 a.m. and slept for a few hours; SP1 was on duty during that time. According to SP2, SP1 stayed to cover the overnight shift because another staff person had called in. SP2 recalled that AV1 entered the office and spoke with SP1 in the morning hours while s/he was cleaning.
- SP2 acknowledged that s/he was friends on social media with AV3 and that AV3 and her/his child went to the same school, but then clarified that AV3 and her/his child were friends on social media and SP2 was not friends on social media with any clients.
- SP2 stated that AV3 had never been to her/his residence. SP2 did not recall the Facebook message from AV3 asking SP2 to check her/his couch for AV3's vape. SP2 noted that P2 had accessed her/his social media, which s/he asked P2 about on January 8, 2024, and P2 responded by telling SP2 that s/he was not allowed to return to the facility. SP2 stated that no clients have been to her/his residence.
- SP2 denied ever sending any clients inappropriate pictures. SP2 was aware that AV1 and AV4 had left the facility and that s/he never advised or encouraged clients to leave or yelled at clients.

- SP2 denied interfering with any clients' urinalysis tests that were conducted weekly as part of the program; tests are sent to an offsite location and has never entered different results on a client's treatment plan but could not rule out making a clerical error.

SP2 provided the following information to LE:

- SP2 was not aware of AV1 seeing any photos or videos of SP1 and SP2 on SP1's phone. SP2 denied any knowledge of any message exchange between SP1 and SP2 referencing oral sex but noted that AV1 made a similar comment to another client at the facility.
- Regarding December 31, 2023, SP2 stated that s/he and SP1 had gone out to dinner with friends. SP1 and SP2 stopped at the facility where SP1 helped pass meds. SP1 and SP2 had received a call that AV1 and AV4 were struggling and talking of running away. It was unclear if they picked up AV1 and AV4 and drove to a park or met them at the park around 9 p.m. SP2 stated that they were at the park for 15 minutes, at most, long enough to convince AV1 and AV4 to return to the facility. AV4 was smoking a cigarette. SP1 and SP2 never took them to McDonalds but that AV1 and AV4 told others at the facility that SP1 and SP2 took them out to Minneapolis, let them drink, and let them smoke cigarettes and weed. SP2 stated that there was no cup of alcohol in the car, s/he does not drink and drive because s/he had a driving while intoxicated (DWI) offense in the past.
- AV1 was successfully discharged but returned back to the facility sometime in November of 2023. During the time that AV1 had been out of the program, SP1 and SP2 planned a trip to SP1's cabin in northern MN. SP1 had been communicating with AV1 who was struggling and likely to relapse, SP2 did not like that SP1 said they were making a side stop and visited AV1 at her/his home in Bemidji. AV1's parent was okay with the visit because AV1 had a good relationship with SP1. They visited AV1 at her/his home and then went to a park together.
- SP2 stated s/he communicated with AV1 on Snapchat but did not do so unless AV1 was struggling and not receiving services from the facility.
- Regarding the selfie of SP2 and AV1, SP2 did not recall taking pictures with AV1. Regarding the message from AV3 about leaving her/his vape pen at SP2's home, SP2 stated that AV3 and her/his family member were messaging each other through SP2's Facebook Messenger. SP2 denied ever provided any client with cigarettes, alcohol, vapes, or that any of the clients from the facility have been to SP2's house.

P1 and P2 provided the following information:

- On the weekend of January 5, 2024, P1 received a phone call from P3 about quitting because s/he did not feel supported at the facility. P1 and P2 received an email from SP2 saying that s/he worked a 22-hour shift and did not want to be disturbed; P1 noted that it was strange for SP1 and SP2 to work an overnight shift together. P1 contacted SP2, who said that s/he was cleaning due to COVID-19 and that for the rest of the night SP1 and SP2 were in the office doing quarterly books. P1 checked video cameras and noticed that SP1 and SP2 were in the office most of the night and did not do periodic bed checks on residents as required and forged documents to show that they had. P1 had scheduled a meeting with SP2 on January

8, 2024, but SP2 called in sick. P1 spoke with P3 and learned about the complaints from residents of SP1 and SP2 taking residents to McDonalds.

- P1 and P2 learned that on the overnight shift of January 4, 2024, AV1 spent time in the office; AV1 left the office around 2:30 a.m. According to AV1, s/he spent time in the office on SP2's phone playing games and on social media. Short of a crisis with a resident, residents should not be in the office, there was no documentation regarding any crisis at that time.
- P1 spoke with AV1's parent, who voiced concerns about SP1 and SP2 visiting AV1 in Bemidji, daily contact on the phone and social media. P2 noted that SP2's work laptop was at the office and saw that SP2 was still logged into Facebook and there were messages with a former client. There is a facility policy that employees cannot have any contact with former clients within two years of their discharge from the program.
- P2 stated that they spoke with residents on January 8, 2024, and learned that SP2 had given cigarettes to AV1, AV2, and AV4. Residents denied being provided alcohol, but it was learned that AV3 drank alcohol at SP2's house. During P1's and P2's review of allegations against SP1 and SP2, they learned that AV3 had spent a lot of time at SP2's home drinking and smoking. P1 stated that SP2 had logged onto her/his social media account using a facility computer and remained logged on allowing P1 to see messages sent to AV3 telling her/him to stay quiet and not trust P1 because s/he had relapsed to using drugs. On January 8, 2024, P1 called AV3's parent, who hung up on P1. P1 later found Facebook messages between AV3 and SP2 about that attempt to contact AV3's parent. In one of the messages, SP2 wrote "Block [P1] from both of their phones. And [the facility] and my office."
- P1 stated that staff persons were not allowed to take residents to their homes or have contact with residents for two years of a resident's completion of a program.
- Prior to learning about the allegations regarding SP1 and SP2, there were no concerns other than SP2 sometimes "yelling" at residents.
- Some of the social media pictures, they found, were taken in the office, could tell pictures were taken in the office because of the wall decorations in the background. SP2 had logged onto her/his social media account using a facility computer and had remained logged on.
- Most of the social media that residents had with SP1 and/or SP2 was while the residents were on a pass from the facility, visiting family at home. Some contact occurred when residents borrowed a cellphone from a staff person; staff persons were reminded of the use of cellphones policy at the facility.
- AV1 and AV4 had both left the facility without permission on January 4, 2024, allegedly because SP1 or SP2 yelled at residents but returned quickly thereafter. AV4 again left the facility on January 6, 2024, and her/his whereabouts were unknown. No one had further information about SP1 and or SP2 yelling at residents.

Note: According to a facility incident report and LE records, AV1 was not with AV4 on January 4, 2024.

P3 provided the following information:

- On January 5, 2024, P3 returned to the facility after having COVID-19. P3 learned from a resident that SP1 came to the facility on December 31, 2023, and took AV1, AV2, and AV4 out of the facility, sometime between 8:30 and 9 p.m.; they were taken to McDonalds and given cigarettes.
- On January 6, 2024, SP1 took AV1 offsite, sometime between 5:30 and 6 p.m. under the guise of going to purchase hygiene products but went to SP2's house to have dinner. AV1 informed P3 that SP2 smelled like alcohol and gave AV1 cigarettes. AV1 posted a picture on Snapchat of her/him at the house with SP2 in the background.

The facility's personnel and training records showed that SP1 and SP2 were trained on the facility's policies and procedures and on the Maltreatment of Minors Act prior to the alleged incidents.

Law enforcement also investigated allegations against SP1 and SP2, no criminal charges were filed.

Conclusion:

A. Maltreatment:

Regarding SP1 and or SP2 yelling at AV1 and VA4 causing them to leave the facility:

It was alleged that AV1 and AV4 left the facility because either SP1 or SP2 had yelled at them. According to the facility both AV1 and AV4 left the facility on January 4, 2024, but returned later that same day but on January 6, 2024. AV4 again left the facility and to date had not returned. AV1 did not provide additional details regarding this allegation. AV4 could not be interviewed because s/he did not return to the facility and her/his whereabouts were unknown. Both SP1 and SP2 denied yelling at residents. There was not further information regarding SP1 and or SP2 yelling at residents.

Given there was no further information and no details regarding SP1 and or SP2 yelling to determine what happened, and that there was no further information that SP1's or SP2's actions were related to AV1 and or AV4 leaving the facility, there was a preponderance of the evidence that there was not a failure to provide AV1 and AV4 with necessary care.

It was determined that neglect did not occur (failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so. Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so).

Regarding SP1 and SP2 having inappropriate boundaries:

Information was consistent that, contrary to facility policy, SP1 and SP2 had personal relationships outside of the facility with AV1, AV2, and AV3. Both SP1 and SP2 visited AV1 at AV1's home during the summer of 2023; according to facility records, AV1 was still a resident of the facility at that time. AV1 and AV2 both stated that on December 31, 2023, both SP1 and SP2 went to the facility after a night out with friends and took AV1, AV2, and

AV4 to McDonald's and then to a nearby park. At some point, SP2 provided them with cigarettes; AV1 noted SP2 smelled of alcohol. On January 4, 2024, AV1 visited with SP1 and SP2 in the facility office during late night hours of the night accessing social media. On January 6, 2024, under the guise of taking AV1 to purchase hygiene products SP2 took AV1 out of the facility but instead took AV1 to SP2's residence for dinner and again provided cigarettes. AV1 stated that SP2 drank alcohol before driving AV1 back to the facility.

AV1 and AV2 provided information that SP1 and SP2 shared photos and included them in discussions of a sexual nature. SP1 denied directly showing AV1 photos of an adult nature but claimed that AV1 came upon such a photo inadvertently when AV1 used SP1's phone and saw that photo as SP1's background on her/his phone. SP1 and SP2 denied including AV1 or AV2 in any discussion of a sexual nature; SP1 denied showing AV1 or AV2 any other photos of an adult nature.

Information was consistent that AV3 was a regular visitor to SP2's residence. SP2 and AV3 stated that AV3 was friends with relatives of SP2. Social media messages exchanged regarding AV3 leaving her/his vape at SP2's residence was allegedly with SP2's relative using SP2's social media account. Although AV3 stated that s/he never visited SP2's residence while in the program, P4 stated that AV3 regularly visited SP2's residence for at least a year and G3 also stated AV3 was at SP2's residence.

Although SP1 and SP2 denied making nicotine or vapes available to AV1, AV2, AV3, and AV4, information was consistent that SP2 smoked and social media posts between AV3 and SP2 established that AV3 left her/his vape at SP2's residence and engaged in vaping at SP2's residence.

There was inconsistent information provided by SP1 and SP2. Regarding December 31, 2023; SP1 stated that s/he went to the facility alone but SP2 stated that s/he visited the facility afterhours with SP1 on the night that SP1 and SP2 were alleged to have taken AV1, AV2, and AV4 to McDonalds and a nearby park and providing them with cigarettes. SP2 stated that s/he brought food from McDonald's but never took residents there. SP2 told LE that s/he and SP1 were at a park with AV1 and AV4 for about 15 minutes but never took them to McDonald's. SP1 denied any knowledge of any residents seeing nude photos of either SP1 or SP2, however SP1 told LE that photos were not of SP2 but of an ex-partner. SP2 lacked credibility regarding the exchange of messages between SP2 and VA3 in which they discuss P1's attempts to contact AV3's guardians after the facility learned of the allegations in this report, as well as the message regarding AV3 leaving her/his vape at SP2's house.

SP1 and SP2 provided inconsistent information and had reason to minimize their actions for fear of consequences therefore the AVs' accounts of the allegations were considered more credible than the SPs' accounts. It was more likely than not that SP1 and SP2 engaged in behaviors which were inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services and with the facility's policies.

Given that the AVs had histories of substance use disorders, it was reasonable that the AVs would continue to need supports to develop and maintain the necessary life and social skills to maintain sobriety. The SPs' interactions with the AVs hindered the AVs' ability to have a consistent understanding of the parameters of a therapeutic relationship which could interfere with other individuals' attempt to provide therapeutic services to the AVs, both now and in the future. Therefore, there was a preponderance of the evidence that the SPs failed to maintain professional boundaries and that the SPs' interactions with the AVs were determinantal to the AVs' ongoing mental health. In addition, AV1 and AV2 provided consistent information that SP2 provided them with cigarettes which was illegal because the AVs were not of legal age. Given those reasons, there was a preponderance of the evidence that SP1 and SP2 each failed to provide AVs necessary care and failed to protect

the AVs from actions that seriously endanger the AVs' physical or mental health.

It was determined that neglect occurred (failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so. Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

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

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

SP1 and SP2 were trained on the Reporting of Maltreatment of Minors Act and the facilities policies and procedures. SP1 and SP2 were responsible for maltreatment of the AVs.

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 neglect for which SP1 and SP2 were responsible was not serious because the AV's had no known injuries and did not require the care of a physician.

It was determined that the substantiated neglect for which SP1 was responsible was not recurring because SP1's behavior of inappropriate boundaries was considered a single pattern of behavior.

It was determined that the substantiated neglect for which SP2 was responsible was recurring because SP2 provided AVs with cigarettes, which were illegal for the AVs, on more than one occasion and SP2's inappropriate boundaries was considered a pattern of behavior.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (c) all investigative data maintained in this report will be kept by the Department of Human Services for at least ten years after the date of the final entry in the report.

D. Person Regulated by Health-Related Licensing Boards

Pursuant to Minnesota Statutes, section 245C.31, subdivision 1, when individuals regulated by a health-related licensing board are determined to be responsible for substantiated maltreatment under Minnesota Statutes, section 260E or 626.557, instead of the Commissioner of the Department of Human Services making a decision regarding disqualification, the licensing board makes a determination whether to impose disciplinary or corrective action under Minnesota Statutes, chapter 214.

SP2 is regulated by a health-related licensing board. The health-related licensing board was notified upon issuance of the investigation memorandum that SP2 was determined to be responsible for serious

maltreatment and would be disqualified from direct contact if s/he were not regulated by the board.

Action Taken by Facility:

The facility completed an *Internal Review* and determined that policies and procedures were adequate but were not followed. SP1 and SP2 were no longer employed by the facility.

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

SP1 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of SP1. The determination that SP1 was responsible for maltreatment is subject to appeal.

The health related board that SP2 was regulated by was notified that SP2 was determined to be responsible for recurring maltreatment and that the SP would be 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 if SP2 was not regulated by a health related licensing board.

Certification:

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.