

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: 202400875

Date Issued: July 17, 2025

Name and Address of Facility Investigated:

Nexus Mille Lacs Family Healing
407 130th Avenue South
Onamia, MN 56359

Disposition:

Allegation One: Maltreatment determined as to sexual abuse and neglect of an alleged victim (AV1) by a staff person (SP).

License Number and Program Type:

1036935-CRF (Children's Residential Facility)

Allegation Two: Maltreatment determined as to physical and neglect of an alleged victim (AV2) by the SP.

Investigator(s):

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Suspected Maltreatment Reported:

Allegation One: It was reported that a staff person (SP) allowed an alleged victim (AV1) to touch the SP's leg, thigh, and buttocks, and give the SP a hug without stopping or addressing the interactions.

Allegation Two: It was reported that the SP slapped an alleged victim's (AV2) mouth causing him/her to have a swollen lip.

Date of Incident(s):

Allegation One: January 15 and 20, 2024; and other dates unspecified

Allegation Two: January 20, 2024

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph

(a), clauses (1) and (2); subdivision 20; subdivision 18, paragraph (a); and subdivision 23, paragraph (a):

"Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, or by a person in a current or recent position of authority to any act that constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse includes threatened sexual abuse.

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.

"Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means. "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on February 16, 2024; from documentation at the facility; and through nine interviews conducted with AV1, AV2, AV1's and AV2's respective family members (FM1 and FM2), facility staff persons (the SP and P1), supervisory staff persons (P2 and P3), and a public-school employee (PSE).

The facility provided residential treatment for youth ages 10 to 18, who were needing additional support with emotional-, behavioral-, and mental health- needs. The facility provided supervision, therapy, medication management, recreation, and education.

The facility's boundary and professionalism policies and procedures stated that staff should not engage in "red flag" behaviors, including:

- Spending notably more time with one youth to the exclusion of others.
- Allowing a youth to break rules.
- Sticking up for a youth against the rest of the staff.
- Creating situations of being physically isolated with a youth.
- Inappropriately touching a youth or allowing a youth to inappropriately touch the staff; this included on the leg, buttocks, sitting on a lap, etc.
- Talking sexually to or in front of a youth.
- Disclosing excessive personal information to a youth.
- "Rough housing," tickling, pinching, etc., a youth.

Facility documentation stated that the SP, P1, P2, and P3 received training on the facility's boundaries and professionalism policies and procedures including red flags, and on the Reporting of Maltreatment of Minors Act.

Allegation One: *It was reported that the SP allowed AV1 to touch the SP's leg, thigh, and buttocks, and give the SP*

a hug without addressing or stopping the behavior.

At the time of the incident, AV1 was 15 years old, and his/her diagnoses included attention-deficit hyperactivity disorder and disruptive mood disorder. AV1 wanted to work on emotional regulation and family reunification.

AV1 provided the following consistent information during separate interviews with the DHS investigator and with P2 for the facility's internal investigation:

- AV1 "hung out" with the SP and "defended" the SP against other youth when it was alleged the SP made a "hated list" of youth names and rankings. AV1 never saw a list.
- The SP told AV1 that s/he was the SP's "favorite youth."
- One time, they were in the gym and the SP showed AV1 and other unidentified youth pictures of a "stripper" on the SP's cellphone. The SP told them that s/he saw the stripper at a "strip club" and "smacked [the stripper's] butt."
- At least once, the SP held AV1's hand.
- Once while playing basketball, an unidentified youth blocked a shot and accidentally struck AV1's "nipple." The youth then jokingly called the play "a breast block." The SP heard this, approached AV1, and "caressed [the SP's own] breast right in front of [AV1]." [Note: The word "breast" was used by AV1 to describe the incident and will later be used by others within this report; however, this should not be used as an indicator of the gender and/or the genitalia of anyone, including AV1 or the SP.]
- One time, the SP put his/her hand around AV1's head and "put [AV1's] head on [the SP's] breast." [Note: AV1 did not state whether there was clothing covering the SP's breast. That said, there was no information the SP's breast was exposed or unclothed.]
- One time, AV1 wanted to talk to the SP and the SP called him/her over to where the SP was sitting, which was on a gym mat on the floor with the SP's legs outstretched. AV1 asked where s/he should sit and the SP said, "Here, just put your head on my leg." AV1 then lay down next to the SP and put his/her head on the SP's upper right thigh. While they were talking, the SP told AV1, "I'm sorry if it stinks down there." AV1 asked, "What do you mean?" The SP said, "My [genitals]. I'm pretty sure it stinks." AV1 did not smell anything.
- One time, AV1 was on the stairs taking two steps at a time and grabbed the railing but his/her hand swung forward and struck the SP's buttocks. The SP responded by stating that AV1 struck the SP's buttocks on purpose and said to AV1, "I know you want to fuck me."
- Another time, they were talking about peanuts. AV1 asked the SP if s/he liked peanuts and the SP said, "I like nut in me." AV1 believed the SP's use of the word "nut" meant "semen," as to say, "I like [semen] in me." [Note: The word "semen" was used by AV1 to describe the incident and should not be used as an indicator of the gender and/or the genitalia of AV1 or the SP.]
- One time, AV1 was talking about a rapper and told the SP that the rapper was "cute." The SP responded

to AV1, "Wow. You're cheating on me. You don't want this [the SP's genitals] no more?"

- One time, AV1 gave the SP a hug from behind and "accidentally" touched the SP's breasts. AV1 stood there and was like, "What the hell" before pulling away from the hug. The SP did not say anything or pull away from AV1 during the hug.
- The SP also told AV1, "Guess what my favorite sex position is?" and "I know you think I'm hot." The SP said that s/he wished AV1 was 18 years old and that the SP "would fuck [AV1] if [s/he] was 18."
- Another youth (Y2) told AV1 that the SP said the same thing to Y2 about wishing Y2 was 18 years old. AV1 did not see this happen.
- Another youth (Y1) told AV1 that the SP "grabbed [Y1's genitalia]." AV1 did not see this happen. Y1 told AV1 that one time, s/he was trying to dunk a basketball and accidentally touched the SP's breast, and that the SP responded by saying to Y1, "That was fun. Do it again." AV1 did not see this happen.
- AV1 got "super defensive over" the SP with other youth and felt "weird" that the SP might have said similar things to Y1 and Y2. The SP made AV1 feel "really special." AV1 was "scared" to talk about the SP with the DHS investigator because the SP once told AV1, "Don't snitch (on me). I will get in deep trouble."

Video footage, that had no date or time stamp, of the facility's youth bedroom area showed the SP sitting at a desk with a laptop in front of him/her on a table. AV1 walked behind the SP and wrapped his/her arms under the SP's arms and around the SP's torso so that both of AV1's hands were on the front of the SP's chest. AV1's head was resting on the SP's shoulder or touching the SP's head. The SP did not appear to say anything or pull away from AV1. The SP remained still with his/her hands on the laptop. The contact lasted approximately 14 seconds before AV1 let go and walked away. At a later point in the same video, AV1 sat in a chair next to the SP and the two sat shoulder to shoulder (touching shoulders and upper arms) while the SP typed on the laptop.

The PSE provided the following information:

- On January 30, 2024, AV1 said that s/he "really, really needed" to speak to the PSE. They met, and AV1 told the PSE that s/he had a "special bond" with an unidentified staff person. AV1 said that s/he "felt guilty" that this staff person might get in trouble because of his/her relationship with AV1. AV1 said that they had "special conversations" and that the staff person "cared about [AV1] more than anyone else." The PSE asked AV1 if any sexual boundaries were crossed and AV1 said, "We didn't have sex, but" and then refused to say anymore.
- AV1 did not identify the staff person by name but told the PSE that the staff person was out on leave at that time. The PSE knew the "only staff" who was out on leave at the time was the SP.
- The PSE added that AV1 had a history of "exaggerating" and "attention seeking." However, when AV1 spoke about the SP's conduct, s/he appeared "sincere" and "upset."
- On February 5, 2024, AV1 told the PSE that s/he was "scared" the SP might "retaliate" against AV1 because of what AV1 previously shared about the SP's conduct. AV1 was "worried" that the SP "really liked [AV1]" and might try to touch AV1 "inappropriately." The SP had previously made comments to AV1, like, "I want to fuck you," "I want you to nut in me," and "I want to have sex with you." One time,

the SP “suggestively rubbed [his/her own] breasts” in front of AV1. Another time, AV1 hugged the SP and “accidentally brushed [the SP’s] breast,” and the SP responded, “Yeah, I know you want me bad.”

P1, P2, and P3 provided the following information:

- P3 said that on January 15, 2024, s/he went to the gym to check-in with the youth. The SP was in the weight room with some of the youth. When P3 finished talking to the various youth, s/he left the gym, and the door closed behind him/her. However, s/he immediately turned back because s/he forgot to say goodbye to the SP. P3 reopened the gym door and saw the SP sitting on a gym mat with AV1 and Y1, who were sitting “incredibly close” to the SP. P3 told AV1, “Scootch away.” In response, AV1 stood up and got “mad at” P3. The SP “just sat there.” P3 left the gym and told P2.
- P2 said that s/he talked to the SP about allowing the youth to sit “too close” in the gym; “Almost sitting on [the SP’s] lap.” During this conversation, the SP “got argumentative” with P2 and said that the distance s/he was sitting from the youth was “not a big deal, I don’t mind it.”
- P1 said that on January 20, 2024, s/he walked into the gym and saw the SP sitting on a gym mat on the floor with AV1 lying next to him/her with his/her head resting on the SP’s thigh. P1 told them, “Boundaries,” and the SP responded by saying, “[AV1’s first name] is fine.” P1 did not say anything further because s/he did not want to start an argument with AV1 present.
- P2 and P3 each said that following P1’s observations in the gym on January 20, 2024, AV1 appeared “dysregulated” in the living room and wanted to speak privately to the SP. However, it was suppertime, and the SP was supposed to be in the cafeteria supervising youth. P2 told the SP to go to the cafeteria, six or seven times, and each time, the SP refused. Then another supervisor arrived, who “firmly” told the SP to go to the cafeteria. The SP was “very visibly disgusted” but did leave to the cafeteria. AV1 walked with the SP to the cafeteria.
- P1 and P3 each, separately, asked AV1 about the incident in the gym on January 20, 2024. AV1 provided consistent information to P1 and P3 that while AV1 had his/her head on the SP’s thigh, the SP said, “I hope it doesn’t stink down there,” which AV1 believed was referring to the SP’s genitals. AV1 told P3 that this made him/her uncomfortable. AV1 also told P3 that the SP wished AV1 was the SP’s boy/girlfriend and wanted AV1 to “nut” the SP. One time, the SP told AV1, something like, “We can’t date. I wish you were 18.” AV1 told P3 that the SP showed him/her pictures of “a stripper’s profile” on the SP’s cellphone.
- P3 said that on January 21, 2024, another youth (Y3) mentioned that the SP and AV1 were hugging in the bedroom area. This prompted P3 to review the camera footage. P3 said that staff were not allowed to hug a youth or sit next to a youth. Y1 told P3 that the SP showed him/her “a stripper profile” and pictures of the SP at a “strip club” on the SP’s cellphone. Y2 told him/her that one time on the gym mat, s/he put his/her leg over the SP’s leg. This was all Y2 had shared about his/her interactions with the SP. Y2 did not want to talk about it further.

FM1 said that AV1 told him/her there was an unidentified staff who made comments about wishing AV1 was 18.

The SP provided the following information:

- At times, AV1 sat “too close” to the SP or said “things (to the SP) that [AV1] should not,” like that the SP was “cute” and that AV1 had a dream about having sex with the SP. When this occurred, the SP told AV1 to stop saying or thinking such things.
- Regarding the hug as seen on camera footage, the SP said that AV1 wanted a hug and walked up behind and hugged the SP. The SP told the DHS investigator, “I don’t know what the big deal was.” Staff could give “half hugs” to youth or a “full on hug” if there was another staff person present. AV1 gave the SP a “full on” hug, not a half-hug. There were no other staff present. The SP did not tell AV1 to stop the hug at that time. The SP planned to talk to AV1 later and tell him/her not to hug staff. However, allegations were raised about the SP’s conduct with AV1, and the SP never got the chance to talk to AV1 about the hug.
- The SP said that AV1 never rested his/her head on the SP’s thigh but did put his/her head on the SP’s shoulder at least once. The SP denied saying anything to AV1 about the smell of the SP’s crotch and denied showing AV1 pictures of a stripper.
- One time, the SP told AV1 that s/he wished AV1 was 18 years old. The SP was “embarrassed” for saying this and only said it to not “hurt [AV1’s] feelings.” The SP had no intention of dating AV1 and did not want a relationship with AV1.
- The SP believed the allegations were made because “some youth were trying to get [the SP] fired.”
- The SP was trained to not cross boundaries with youth.

Note: The SP was about ten years older than AV1.

Relevant Statute:

Minnesota Statutes section 609.341 defines “intimate parts” as including the primary genital area, groin, inner thigh, buttocks, or breast of a human being; and defined “sexual contact” as including the touching by the complainant of the actor’s, the complainants, or another’s intimate parts effected by a person in a current or recent position of authority. In any of the cases, this included the touching of the clothing covering the immediate area of the intimate parts.

Conclusion for Allegation One:

A. Maltreatment:

AV1 provided consistent information to the DHS investigator, P2, P3, and the PSE that the SP lay AV1’s head on the SP’s breast, allowed AV1 to lay his/her head on the SP’s upper thigh while making a comment regarding the smell of his/her genitals, and made comments more than one time about wanting to “fuck” AV1 and for AV1 to “nut” the SP. AV1 also stated that the SP showed AV1 and other youth a picture of a stripper, about his/her interactions with the stripper, and caressed his/her own breast in front of AV1. AV1 told the PSE that s/he had a “special bond” and “special conversations” with the SP, which made AV1 feel “guilty.” The PSE believed AV1 appeared “sincere” and “upset.” P1-P3 each saw the SP interacting with AV1 in a manner that included sitting “incredibly close,” laying AV1’s head on the SP’s upper thigh, and becoming “argumentative” when his/her

conduct was questioned by other staff. Y1-Y3 also provided information about similar incidents with the SP's conduct.

The SP said that s/he redirected AV1 when AV1 sat too close to him/her or commented to the SP about AV1's dreams. The SP denied that AV1 lay his/her head on the SP's thigh, denied commenting about the smell of his/her genitals, and denied showing AV1 a picture of a stripper. The SP also said s/he was trained to not cross boundaries with youth.

Video footage showed AV1 hugging the SP from behind with his/her arms under the SP's arms, around the SP's torso, so that both of AV1's hands were on the front of the SP's chest. The hug lasted for about 14 seconds with AV1 eventually letting go and without the SP stopping or addressing the behavior.

Regarding AV1 touching the SP's "breast," it was unclear if this was accidental as described by AV1. However, given that AV1 provided consistent information about the SP's sexualized statements or conduct to more than one person and that others saw conduct consistent with AV1's information, it was determined that the account provided by AV1 was more credible than the SP's accounts.

Regarding sexual abuse:

AV1 was 15 years old at the time and living at the facility seeking help with his/her diagnoses, emotional regulation, and family reunification. The SP was about ten years older than AV1. Given the information provided by AV1, FM1, Y1-Y3, and P1-P3, there was a preponderance of the evidence that the SP's conduct included statements and overt acts that represented a substantial risk of sexual abuse to AV1 and/or included the touching of intimate parts.

It was determined that sexual abuse occurred (the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 - 609.3451 [criminal sexual contact in the first through fifth degree]).

Regarding neglect:

Given AV1's age and that s/he had diagnoses that would reasonably be expected to require some level of continued supports and services throughout his/her life, the SP's interactions with AV1 likely hindered AV1's ability to have a consistent understanding of the parameters of a therapeutic relationship, which could interfere with other individuals' attempts to provide him/her with therapeutic services, both now and in the future. Therefore, there was a preponderance of the evidence the SP's interactions with AV1 were detrimental to AV1's ongoing mental health and were a failure to supply necessary care and to protect from conditions that seriously endanger AV1's physical or mental health when reasonably able to do so.

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.

The SP received training on the facility's *Boundaries, Red Flags, and Professionalism*, and on the Reporting of Maltreatment of Minors Act.

The SP was responsible for maltreatment of AV1.

C. Recurring and/or Serious Maltreatment: See Allegation Two.

Allegation Two: *It was reported that the SP slapped AV2's mouth causing him/her to have a swollen lip.*

At the time of the incident, AV2 was 12 years old, and his/her diagnoses included attention-deficit hyperactivity disorder and disruptive mood disorder. AV2 wanted to work on emotional regulation and family reunification.

AV2 said that one day, the SP was "playing" or "horseplaying around," and put his/her hand over AV2's mouth. It did not feel like a slap. "It wasn't a slap" but a "tap" "into a shove" but, which caused AV2 to bite his/her upper lip. AV2's upper lip was pushed into his/her tooth and there was a "cut" inside his/her mouth. "I think [the SP] was doing it to play around, but to me, I did not like that." When AV2 went to tell someone about it, the SP called AV2, "a snitch." As the day went on, the SP "antagonized" AV2 and later when another youth "mocked" AV2, the SP "laughed." Then "the whole program ganged up on" AV2 for "snitching on" the SP.

P1 said that s/he saw the SP "pop" or "smack" AV2's mouth. The SP then laughed and said s/he was "joking around." AV1 and Y1 were present and also laughed. When AV2 walked away, the SP stated that AV2 was going to do what s/he "does best," which was "snitch." AV2 later told P1 that the SP was "joking around" with AV1 and Y1, and "popped" AV2's mouth for "no reason." According to P1's incident report, the day was January 20, 2024.

P2 said that Y1 told him/her that s/he saw the SP "pop" AV2's mouth. P2 asked other unidentified youth about the incident, and some said the SP was joking around and some said the SP was not joking. "But all had in

common that [the SP] did put [his/her] hand on [AV2] and [AV2's] mouth whether it was aggressive or not aggressive is unclear." There was no video footage of the incident. P2 added that regardless of the circumstances, staff should not put their hands on a youth. "We don't horseplay with youth." P2 asked the SP about the incident and the SP said that they were "horseplaying." The SP told P2 that s/he was "not being mean," but did put his/her hand on AV2's mouth. The SP denied slapping AV2's mouth.

The facility's *Incident Report and Review*, written by P2, stated that AV2 "possibly bit [his/her] lip." There was no medical response to the incident and/or injury recorded by P2.

The SP said that s/he and AV2 were "messing around," during which, AV2 put his/her hand over the SP's mouth and the SP did the same thing to AV2 in return. The SP covered AV2's mouth with the SP's hand. AV2 responded by "laughing about it." "We went on about our day ... Not a huge issue until now." When AV2 told another staff about what happened, the SP did not call him/her "a snitch," but did say, "Great. I am in trouble. Thanks." The SP said that s/he did not slap AV2's face.

FM2 did not have concerns or additional information relating to this incident.

Information maintained by the Department of Human Services (Report Number 2023000825) showed that on June 16, 2023, it was determined that the SP was responsible for physical abuse. On January 24, 2023, after a three-year-old child hit the SP in the face, the SP slapped AV1 in the face causing a "red" or "pinkish" mark. It was a single incident and although the SP stated that the mark lasted a "couple of days," the child's family member stated the mark was gone the next day so it was not determined whether the mark left was tissue damage or transitory in nature. The decision was not appealed.

Conclusion for Allegation Two:

A. Maltreatment:

AV2 said that the SP "tapped" his/her mouth while joking around, which caused AV2 to bite his/her upper lip; "It wasn't a slap but a slap into a shove ... more of a tap than a slap." P1 saw the SP "pop" or "smack" AV2's mouth. P2 said that Y1 told him/her that the SP "popped" AV2's mouth and some said the SP was joking around and some said the SP was not joking. AV2 and P2 also provided information about the SP calling AV2 "a snitch" for talking about the incident.

The SP said that s/he was "horseplaying" and put his/her hand on AV2's mouth. The SP denied slapping AV2's mouth and denied calling AV1 "a snitch." The SP's conduct was inconsistent with the facility's boundary and professionalism policies and procedures, which stated that horseplaying was not allowed.

Regarding physical abuse:

Although the SP's actions were described as joking or horseplaying, touching a child on the mouth that was described as slapping/slapping into a shove/tapping/popping in a manner such that the child bites themselves, is not accidental. Therefore, there was a preponderance of the evidence that the SP's actions caused injury to AV2 and represented a risk of physical injury.

It was determined that physical abuse occurred ("physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means.

"Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury).

Regarding neglect:

AV2 was 12 years old at the time and living at the facility seeking help relating to his/her diagnoses. The SP put his/her hands on AV2's face and caused AV2 to bite his/her lip. When AV2 went to tell someone about the SP's conduct, the SP's reaction included calling AV2 "a snitch" in front of other youth, allowing other youth to "mock" AV2, laughing at AV2, and prompting the "whole program to gang up on" AV2. The SP's conduct was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services.

Given AV2's age and that s/he had diagnoses that would reasonably be expected to require some level of continued supports and services throughout his/her life, the SP's interactions with AV2 likely hindered AV2's ability to have a consistent understanding of the parameters of a therapeutic relationship, which could interfere with other individuals' attempts to provide him/her with therapeutic services, both now and in the future. Therefore, there was a preponderance of the evidence the SP's interactions with AV2 a failure to supply AV2's with necessary care and a failure to protect AV2 from conditions that seriously endanger his/her physical or mental health when reasonably able to do so.

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:

- (2) 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;
- (3) 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
- (4) whether the facility or individual followed professional standards in exercising professional judgment.

The SP received training on the facility's *Boundaries, Red Flags, and Professionalism*, and on the Reporting of Maltreatment of Minors Act.

The SP was responsible for maltreatment of AV2.

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 maltreatment for which the SP was responsible in this report was recurring and serious. The SP was responsible for sexual abuse and neglect of AV1 and physical abuse, resulting in injury, and neglect of AV2.

The SP was disqualified from providing direct contact services.

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.

Action Taken by Facility:

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

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

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

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.