AMENDED 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."

NOTICE: This Amended Maltreatment Investigation Memorandum supersedes a version dated July 10, 2025, which must be destroyed. The original version contained an incorrect facility name, license number, and program type. The amended version contains the correct information.

Report Number: 202503080

Date Issued: July 10, 2025
Date Reissued: July 31, 2025

Disposition: Inconclusive

Name and Address of Facility Investigated:

Northstar Behavioral Health Fergus Falls
1174 Western Ave.
Fergus Falls, MN 56537

License Number and Program Type:

1114002-SUD (Substance Use Disorder)

Investigator(s):

Scott Brandt
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
scott.j.brandt@state.mn.us
651-431-6556

Suspected Maltreatment Reported:

It was reported that a staff person (SP) had inappropriate boundaries, such as kissing a vulnerable adult (VA), sending nude photos of the SP to the VA, and bringing in contraband (alcohol and vapes) for the VA.

Date of Incident(s): Prior to April 9, 2025

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 2, paragraph (c); and subdivision 17, paragraph (a):

Any sexual contact or penetration between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility. Sexual contact is defined by Minnesota Statutes, section 609.341, as the intentional touching of the intimate parts with sexual or aggressive intent. 'Intimate parts' includes the primary genital area, groin, inner thigh, buttocks, and breast.

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information for this investigation was obtained remotely, including documentation from the facility, from law enforcement records, and through six interviews conducted with two management staff persons (P1 and P2), two facility staff persons (P3 and P4), the SP, and a client (C2). Although this investigator contacted the VA and another client (C1), they did not respond to requests to be interviewed.

The VA's *Treatment Plan* showed that s/he was diagnosed with depression, anxiety, and attention deficit hyperactivity disorder. The VA received services from the facility from March 12 through May 12, 2025.

The facility's *Internal Review* and interviews with P1 and P2 provided the following information:

- On April 9, 2025, C1 told P1 that s/he heard that the SP was "making out" with the VA and that the VA had "inappropriate photographs" of the SP on the VA's phone, which were seen by C1, but C1 did not show those photographs to management. C1 did not provide the name of the person that provided the information to C1. The facility "conducted facility searches" to find the phone but was unsuccessful. C1 also told P1 that a staff person also saw the pictures, but C1 did not remember who that staff person was, and the facility was unable to determine the identity of that staff person.

- The facility interviewed several staff persons. Some of the comments from staff included that the SP "has issues with boundaries where [s/he] gets too personal and over shares too much," that the SP "would hang out with the [clients] in the group room with the lights off," and that the SP "was over[ly] friendly and playing cards with clients."

- When P3 was interviewed, P3 said that the SP "confided" in P3 that s/he was "sneaking around" with the VA. P3 stated that s/he heard "rumors" from clients that the SP brought in vapes and allowed clients "phone privileges" when it was "not time," but P3 had not witnessed this and there was no further information provided. The SP also told P3 that s/he and the VA "met up in a hotel" after the VA discharged from the facility and they "communicated with one another" on cell phones, but the timeframe was not identified. P3 told management that s/he was "threatened" by the SP and that the SP "would get [him/her] in trouble" if P3 "reported anything."

- When the SP was questioned, the SP "denied all allegations." P1 recalled two previous times that the SP had some concerns related to boundaries, but P1 did not recall the specifics of those instances. This investigator asked the facility to provide any written documentation regarding concerns with the SP maintaining professional boundaries with clients, but there was no documentation in the SP's file.

- Although P1 or P2 were aware that there were some concerns related to the SP maintaining boundaries, P1 or P2 did not have information that the SP engaged sexually with the VA.

C2 told this investigator that the SP brought in alcohol, which was in a "Gatorade bottle," and a "couple vapes" for the VA, but C2 did not remember when that occurred. C2 also stated that the VA told him/her that the VA and the SP "made out in the locker room" at the facility, but C2 did not remember when that happened and did not see the incident. C2 did not tell anyone about what the VA told him/her. The VA told C2 that the SP and the VA were in contact with one another, through cell phones, and that occurred while the VA received services at the facility and after the VA discharged, but the VA did not tell C2 the content of the communication.

P3 provided information to this investigator that was like the information s/he provided in the *Internal* Review but added that s/he saw the SP bring in a "Gatorade" bottle even though P3 did not know what was in the bottle. When the SP had the bottle, the SP kept the bottle to him/herself and did not appear to be under the influence of alcohol.

P4 stated that on four or five occasions, the SP watched television with the clients with the door open, but P4 did not remember which clients participated. P4 did not have concerns related to the SP's interactions with the clients. P4 had not seen a staff person bring alcohol or vapes into the facility for client use.

The facility had a *Staff Behavior Policy* which stated that the facility "prohibits personal involvement, sexual in nature, with clients or former clients," and that staff were not allowed to use "mind altering chemicals or medications, prescribed or non-prescribed, that impair the staff's ability to perform daily functions." The facility had a policy which stated that vaping was only allowed outside.

The SP provided the following information:

- When the SP was asked to describe the facility's policy regarding staff/client relationships, the SP stated that was not allowed and "I know the rules." The SP denied that his/her interactions with the VA were inappropriate or different than how s/he interacted with other clients. The SP denied kissing the VA and denied having sexual contact with the VA.

- The SP denied bringing alcohol into the facility and denied providing the VA, or other clients, with vapes. Clients sometimes obtained vapes while on scheduled outings, but they were usually confiscated during room searches. The SP also denied exchanging phone numbers, or communicating, with the VA or other clients.

- When the SP was asked why the Minnesota Department of Human Services would have information regarding the allegations, the SP stated, "I don't know."

The facility's training records showed that all staff persons interviewed for this investigation were trained on the

Reporting of Maltreatment of Vulnerable Adults Act and the VAs specific care plans. Also, the SP received training related to boundaries.

Conclusion:

On April 9, 2025, C1 told P1 that s/he heard that the SP was "making out" with the VA and that the VA had "inappropriate photographs" of the SP on the VA's phone, which were seen by C1, but C1 did not show those photographs to management. C1 did not provide the name of the person s/he heard that from.

C2 told this investigator that the VA told him/her that the VA and the SP "made out in the locker room" at the facility, but C2 did not remember when that happened. C2 also stated that the SP brought in alcohol in a "Gatorade bottle" and a "couple vapes" for the VA, but C2 did not remember when that occurred. P3 said that s/he saw the Gatorade bottle but did not know the contents and that s/he did not see the SP bring in vapes for the clients to use. The VA and C1 did not respond to requests to be interviewed. P4 did not have concerns related to the SP's interactions with the clients and the SP denied all allegations.

Although C1 and C2 had information that the SP and the VA "made out," given neither provided further details including if any intimate parts were touched or what "made out" meant, that when the facility conducted searches, no phones, vapes, or alcohol were found, that the VA did not provide information, and that the SP denied the allegations, there was not a preponderance of the evidence whether the SP had sexual contact with the VA or whether the SP failed to provide the VA with reasonable and necessary care and services.

It was not determined whether sexual abuse or neglect occurred (any sexual contact or penetration between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility. Sexual contact is defined by Minnesota Statutes, section 609.341, as the intentional touching of the intimate parts with sexual or aggressive intent. 'Intimate parts' includes the primary genital area, groin, inner thigh, buttocks, and breast; 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).

Action Taken by Facility:

The facility completed an *Internal Review* and determined that although policies and procedures were adequate, they were not followed. The SP was no longer employed by the facility as on April 21, 2025, and P3 was placed on a "performance improvement plan" for not bringing concerns to management.

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

No action taken.