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: 202500720

Date Issued: October 14, 2025

Name and Address of Facility Investigated:

Alpha Services
3831 3rd Place Northwest
Rochester, MN 55901

Alpha Services Company of Rochester
3900 Fairway Place Northwest
Rochester, MN 55901

Disposition: Substantiated as to neglect of a vulnerable adult by a staff person.

License Number and Program Type:

1069907-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069903-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) brought his/her child (C) to the facility and left him/her unsupervised with a vulnerable adult (VA), and the VA exposed his/her genitalia to the C and/or attempted to pull down the C's pants to expose the C's genitalia. The VA was charged with criminal sexual conduct.

During this investigation, it was also reported that the SP drank alcohol and smoked marijuana with or in the presence of the VA and then drove a vehicle, with the VA as a passenger, while "impaired."

Date of Incident(s): January 23, 2025; other dates unknown

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 February 20, 2025; from documentation at the facility and law enforcement records; and through ten interviews conducted with the VA, the VA's guardian (G), the VA's case manager (CM), the VA's therapist (T), the VA's housemate (H), a facility staff person (SP), and supervisory staff persons (P1-P4).

The VA's *Individual Abuse Prevention Plan* and *Individual Assessment* provided the following information:

- The VA was an avid sports fan and liked being active and social, and hoped to live independently someday.

- The VA's diagnoses included autism spectrum disorder.

- The VA did not always understand boundaries and might be "overly friendly" with strangers, who might misinterpret the VA's intentions. Staff always remained available to assist the VA and "closely monitored" the VA's interactions with strangers. Staff also provided transportation, medication management, and reminders to complete tasks. The VA had up to five hours unsupervised time in the community per day but needed to check-in with staff at certain times by cellphone. "[The VA] can be left alone at home for brief periods of time." [Note: The VA's support plans, reviewed for this investigation, did not include additional specifics regarding the VA's supervision requirements at home.]

- The VA's history included a criminal conviction for having sexual contact with a minor. The VA was "recently" (as of January 2025) released from jail and moved into the facility. The VA was not on probation or restricted from having contact with minors. The VA was "looking for a fresh start" at the facility and hoped to one day live independently and go to college for music. [Note: The VA's support plans, reviewed for this investigation, did not include specific requirements or needs relating to the VA's criminal conviction or contact with minors. The VA did not have any rights restrictions or related supports or services.]

The facility was a single-family home where the VA lived with housemates, including the H. The facility provided staff for the housemates' care and supervision.

A *law enforcement report* stated the following:

- On January 25, 2025, the SP called 9-1-1 stating the VA sexually abused the C at the facility. The C was five-year-old at the time. [Note: The VA was in his/her late 20s at the time.]

- The SP told a law enforcement officer (LEO) that on January 23, 2025, s/he took the C to a dental

appointment and then to the facility around 3 p.m. to finish out the last hour of the SP's workday. The SP received approval from P3 to bring the C to the facility. At that time, the VA and the H were home and the SP was the sole staff person. The SP had previously, on more than one occasion, brought the C to the facility and had also brought the VA to more than one of the SP's family gatherings where the C was present. The C and the VA were familiar with each other and the SP never had concerns with their interactions.

- On January 23, 2025, the VA and the C were playing hide and seek inside the facility. At one point, the C ran out and told the SP, "[The VA's first name] was being naughty ... I didn't do anything wrong. I didn't look." The C told the SP that the VA pulled the VA's pants down and exposed his/her genitalia to the C.

- Shortly after, the SP and the C left the facility without any further interaction with the VA.

- On January 28, 2025, a person, who specialized in interviewing children of alleged sexual abuse, interviewed the C. The C told the interviewer that s/he played hide and seek with the VA and walked into the H's bedroom looking for the VA. The C saw the VA sitting on the H's bed with his/her pants pulled down exposing his/her genitalia. The VA did not touch the C's genitalia. This was the sole time the VA did something like this.

- The LEO arrested the VA and charged him/her with Attempted First-Degree Criminal Sexual Conduct, Attempted Second-Degree Criminal Sexual Conduct, and Indecent Exposure. [Note: At the completion of this investigation, the VA's court proceedings were ongoing.]

The H said that s/he was home when the SP brought the C to the facility, and the C and the VA played hide and seek. The SP was at the dining table completing paperwork and the H was in the living room. The H saw the C enter the H's bedroom looking for the VA and then exit the room "with the strangest look on [his/her] face." The C went to the SP and stated, "[The VA's first name] was being naughty." The H recalled the C might have said something, like, "[The VA's first name] showed me [his/her genitalia]."

The VA provided the following information:

- In the past, more than once, the SP brought the C to the facility because the SP did not have someone to watch the C. At times, the C stayed for up to eight hours at the facility with the SP. The SP "never supervised" or was "hit or miss with supervising" the C when s/he was at the facility and let the C wander around and "do as [s/he] pleases."

- On January 23, 2025, the SP was in the living room talking to the H, and the C was "bothering" the VA to play hide and seek but the VA did not want to. The VA went into his/her bedroom to get away from the C. The VA denied exposing his/her genitalia to the C.

- The VA said that there were times when s/he went to the SP's family gatherings with the SP and the SP smoked marijuana and drank alcohol and then drove the VA back to the facility while "impaired." The SP "swerved" the vehicle "slightly" and one time "crashed into the mailboxes and ruined the whole front of the house."

The CM said that the VA had a history of sexually abusing others. Staff persons were supposed to be aware of the

VA's history and provide "close supervision" or "watch [the VA] engage with people in the house," which was most often the VA's housemates. The CM was not aware of other people being in the house except the housemates, and the housemates' friends and guardians. The CM was never informed of the C, or other personal visitors of the staff, being at the facility. The facility was supposed to "vet" visitors and ensure they were "appropriate to be in the home around the individuals living there." "There is nothing that stated [the VA] should not be around minors."

The G said that the VA was not restricted from interacting with minors. Before January 23, 2025, the VA told the G that the SP brought the C to the house about once a month and that other staff sometimes brought friends or family to the house, which the G thought was "odd." The G did not believe "facility management" knew staff were having personal visitors to the house. The G believed that all visitors were supposed to be "vetted" by "management" and the G was then supposed to be informed of who was visiting. The facility never contacted the G about the C's visits. The VA's supervision at the house was 1:4 (one staff per four housemates) and the VA did not require 1:1 supervision.

The T said that the VA was "adamant" s/he did not expose his/her genitalia to the C. The VA told the T that s/he did not want to play hide and seek, which "angered" the C, and as a result, the C was "lying and trying to get [the VA] in trouble." The T said that the VA was "very honest" and did not have a history of providing inaccurate information.

P1-P4 provided the following information:

- P3 said that on January 22, 2025, the SP text him/her asking if the C could be at the facility for "a few" or "five" minutes following a dental appointment on January 23, 2025, and P3 said, "Okay." Later, P3 learned the C was at the facility for "a lot longer" than a few minutes, which according to P3 was "not acceptable." P3 said that "in retrospect," s/he should not have approved or allowed the C to be at the facility at all. "I take full responsibility for that. That was an error on my part."

- P3 said that on January 24, 2025, the SP text him/her stating the VA "had done something inappropriate, that [s/he] had exposed [him/herself] to [the C]" on January 23, 2025. P3 was "shocked" by this and "didn't know how to handle it." On January 26, 2025, P3 called P4 and told him/her about it. P3 said that s/he should have notified P4 sooner; "It was a mistake on my part."

- P1, P2, and P4 each said that staff should not bring their family members to the facility but that if they wanted to, they needed approval from the housemates' guardians and facility administrators. Although P3 approved the C visiting the facility, the SP did not ask the housemates' guardians.

- P1-P4 each said that the VA's history included a criminal conviction for having sexual contact with a minor. The VA was not on probation and did not have restrictions regarding his/her contact with minors. Staff were informed of the VA's history by reading the VA's support plans and through staff meetings.

- P1 said that s/he was aware the SP brought the C to the facility more than once prior to January 23, 2025. P1 did not approve this but P3 did. P3 said that s/he was not aware of prior times and was only asked by the SP to bring the C the one time, January 23, 2025. P2 and P4 each said that they were not aware the SP brought or asked to bring the C to the facility.

- P3 said that regarding the housemates' visitors, "If there's someone that we aren't familiar with, then we

request a background check be done on them before they can be in the house." P3 was not aware of ongoing instances of staff having visitors or that this was something needing to be addressed with staff. [Note: The facility did not have a policy regarding staff having friends or family visit the facility.]

- P1-P3 each said that the VA could be unsupervised at the facility. P1 said that staff could run errands "for a short time" with the VA remaining unsupervised at the facility as long as the VA stayed inside, which s/he did. P4 said that when the VA moved into the facility, s/he had no unsupervised time but that at some point prior to January 2025, the VA's interdisciplinary team changed the VA's supervision requirements so that s/he could be unsupervised.

- P1-P3 each had ongoing concerns with the SP's conduct as it related to boundaries and communication. P4 was concerned about the SP's "judgement" with bringing the C to the facility.

The SP provided the following information:

- The SP knew that s/he should not bring the C to the facility but said that other staff sometimes brought their children to the facility. The SP asked P3 and P3 said that this was okay to do.

- On January 23, 2025, the SP sat at the facility's dining table completing paperwork while the C and the VA played hide and seek. The SP could see into the living room where the H was sitting, but not into the bedrooms. The SP "wasn't 100% supervising" the C or the VA. After about 20 minutes, the C ran out of the bedroom and told him/her "what happened." The SP got "upset" and "yelled" at the VA. The VA ran into the VA's bedroom and locked the door. About five to ten minutes later, the SP and the C left the house, and they did not have further contact with the VA.

- The SP "didn't know what to do." Either that night or the next day, the SP text P3 and P3 told the SP to hold off on calling 9-1-1 until they got more information about what happened. On January 25, 2025, the SP called 9-1-1.

- The SP said that when s/he started working with the VA, an unidentified supervisor told him/her that the VA was listed on the Minnesota sex/predatory offender registry for having inappropriate contact with a minor. "[The VA] wasn't supposed to have a lot of alone time." There were no specific requirements for staff regarding the VA's history and the facility did not provide details about the VA's case. The VA told the SP that s/he was convicted of having sex with a minor but that the minor had misrepresented his/her age to the VA. The SP said, "I took [the VA] at [his/her] word." "I believed that [the VA] was just a young, innocent [boy/girl] doing something stupid and then, oops, got in trouble." The VA had previously met the C, and the SP did not have concerns with their interactions. The SP "trusted" the VA.

- The SP said that there was a "vetting process" for having visitors to the house, which was discussed at staff meetings. The SP had "no indication [the G] didn't approve" the C's visits but also said the G "probably wouldn't have agreed with it" but "[the G] wasn't around, I guess."

- The SP denied drinking alcohol and/or smoking marijuana and/or driving the VA while impaired. The SP sometimes brought the VA and/or his/her housemates to the SP's family gatherings for holidays or barbeques. During these, the SP supervised the housemates "the whole time." The SP was not aware of

alcohol or drug use at those times and said that s/he did not drink alcohol or smoke marijuana during

times.

Facility documentation stated that the SP, P1, P2, P3, and P4 received training on the Reporting of Maltreatment of Vulnerable Adults Act; and the SP and P1 also received training on the VA's support plans, including *Individual Abuse Prevention Plan*.

Conclusion:

A. Maltreatment:

Consistent information was provided that on January 23, 2025, the SP brought the C to the facility. The C was five years old. Although the SP received approval from P3 to bring the C to the facility, P3 said that s/he approved the C being at the facility for "a few" or "five" minutes and when P3 later learned the C was at the facility for "a lot longer" than a few minutes, P3 said that this was "not acceptable." The SP said that s/he knew the C should not visit the facility and P1, P2, and P4 each said that staff should not bring their family members to the facility. The G and the CM each said that they were not informed of the C visiting the facility and understood that the facility was supposed to be "vetting" visitors, which did not happen with the C.

The VA's history included a criminal conviction for having sexual contact with a minor, which the SP was aware of. The SP said that s/he "wasn't 100% supervising" the C at the facility on January 23, 2025, when the C was playing hide and seek with the VA. The SP could not see into the bedrooms from where s/he was sitting at the dining room table. The SP said that "20 minutes" passed when the C ran out and told the SP what happened which included the VA pulling the VA's pants down and exposing his/her genitalia to the C. The LEO arrested the VA and charged him/her with Attempted First-Degree Criminal Sexual Conduct, Attempted Second-Degree Criminal Sexual Conduct, and Indecent Exposure. [Note: At the completion of this investigation, the VA's court proceedings were ongoing.]

Although the VA's support plans did not specify supervision requirements when at the facility, the plans stated that the VA's interactions with "strangers" should be "closely monitored," the CM said that staff should provide "close supervision" or "watch [the VA] engage with people in the house," and the SP said, "[The VA] wasn't supposed to have a lot of alone time."

Although the VA denied exposing his/her genitalia to the C, given the VA's history with minors the SP's conduct of bringing the C to the facility and allowing the C and the VA to have unsupervised contact including playing hide and seek was inconsistent with the standards of a professional caregiver in a facility licensed by the Department of Human Services, and there was a preponderance of the evidence that there was a failure to supply the VA with necessary care or services considering the VA's physical and mental capacity or dysfunction.

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.

Regarding P3:

P3 received training on the Reporting of Maltreatment of Vulnerable Adults Act. Although P3 approved the SP bringing the C to the facility, P3 did so with the understanding that the C would be there for "a few" or "five" minutes and was reasonable for P3 to believe that the SP would supervise any contact between the C and the VA. Therefore, P3's responsibility was mitigated.

Regarding the SP:

At the time of the incident, the SP was responsible for the VA's care and supervision. The SP received training on the VA's support plans, including *Individual Abuse Prevention Plan*, and the Reporting of Maltreatment of Vulnerable Adults Act.

The SP was responsible for maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

> "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated neglect for which the SP was responsible did not meet statutory criteria to be determined as recurring but was serious maltreatment. The SP was responsible for a single incident of maltreatment. Although there was information the SP brought the C to the facility more than once prior to January 23, 2025, there was inadequate information to determine how long the C was at the facility and the SP's supervision of the C during those occasions.

However, "serious maltreatment" includes neglect when it results in criminal sexual conduct against a child or vulnerable adult. The VA was charged with criminal sexual conduct towards the C, and the result of the court proceedings was ongoing.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were not adequate and not followed. The facility planned to update and define the policy regarding visitors and reviewed the Reporting of Maltreatment of Vulnerable Adults Act with all staff. The SP and the VA did not have a history of similar incidents 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.