

SECOND 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."

SECOND NOTICE: This Amended Maltreatment Investigation Memorandum supersedes a version dated April 16, 2025, which must be destroyed. On October 28, 2025, an Order of the Commissioner of Human Services adopted the recommendation of a Human Services Judge to reverse the determination that the SP was responsible for sexual abuse of VA1. As a result, the disposition was changed to not substantiated, and the Department of Human Services rescinded the disqualification of the SP.

NOTICE: This Amended Maltreatment Investigation Memorandum supersedes a version dated January 24, 2024, which must be destroyed. An administrative reconsideration upheld the SP's responsibility for sexual abuse of VA1; and rescinded the SP's responsibility for sexual abuse of VA2 and neglect of VA1 and VA2. For additional information, see Administrative Reconsideration section of this document.

Report Number: 202308830

Date Issued: January 24, 2024

Date Reissued: April 16, 2025

Name and Address of Facility Investigated:

Date Reissued: November 10, 2025

Marshall County Group Homes, Inc.-Cedar Place North
605 Cedar Avenue
Argyle, MN 56713

Disposition: Substantiated as to sexual abuse and neglect of two vulnerable adults (VA1 and VA2) by a staff person.

Marshall County Group Homes, Inc.
PO Box D
805 Pacific Avenue
Argyle, MN 56713

Amended Disposition: Substantiated as to sexual abuse of VA1 by a staff person. Not maltreatment as to sexual abuse of VA2 by a staff person and not maltreatment as to neglect of VA1 and VA2 by a staff person.

Amended Disposition: Not substantiated

License Number and Program Type:

1068098-H_CRS (Home and Community-Based Services-Community Residential Setting)
1068093-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) had sexual contact with two vulnerable adults (VA1 and VA2).

Date of Incident(s): 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 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 and law enforcement and medical records; and through interviews conducted with VA1's guardian (G1) who was also VA1's family member, VA1's teacher (T), VA2's guardian (G2) who was also VA2's family member, and a facility supervisory staff person (P). VA1 was interviewed by a professional who specialized in interviewing children and vulnerable adults who were alleged to be victims of sexual abuse, and that information was included in this report. VA2 was not interviewed due to his/her limited memory skills. The staff person (SP) initially responded to this investigator's voicemail message but then did not respond to subsequent phone calls, letters, or emails requesting an interview.

VA1's support plan and support plan addendum provided the following information:

- In June 2023, VA1 moved into the facility seeking supports and services relating to his/her diagnoses, including intellectual disability, autism spectrum disorder, fetal alcohol syndrome, and attention deficient hyperactivity disorder.
- VA1 was able to independently (without help from a staff person) complete most of his/her hygiene tasks with "cues and supervision." This included showering, dressing, and wiping after using the toilet. VA1 required help to ensure appropriate water temperatures in showers and baths.
- VA1 did not like being touched by others.

- “[VA1] is vulnerable to sexual abuse due to [his/her] disability. [S/he] may not be capable of defending [him/herself] against sexual abuse and [s/he] may not understand what constitutes sexual abuse. If [VA1] is hurt, the team feels [s/he] may not report it. All staff hired must pass background checks. All staff are in-serviced on reporting abuse. [VA1] is encouraged to communicate if [s/he] is hurt or if someone has hurt [him/her]. [VA1] receives 24-hour staff supervision with awake night staff on duty.”

VA2’s support plan and support plan addendum provided the following information:

- In March 2023, VA2 moved into the facility seeking supports and services relating to his/her diagnoses, including “severe dementia.”
- VA2 required help from staff to shower and complete other hygiene tasks.
- VA2 liked to sleep with his/her bedroom door open. VA2 typically got up “several times” a night to use the bathroom. “[VA2] has a bed alarm on [his/her] bed ... to keep [him/her] safe. Staff are to interact with [VA2] as little as possible during the night as this will cause [him/her] to stay awake rather than returning to bed. During the night, staff may need to direct [VA2] to the bathroom as [s/he] has difficulty remembering where it is.” VA2 had a history of wandering away and/or taking others’ belongings without permission.
- “Due to [VA2’s] level of dementia, [s/he] may not be unable [sic] to defend [him/herself] against sexual abuse or report sexual abuse. [Staff] will redirect [VA2] away from a dangerous situation should it occur and will provide an explanation as to why [s/he] was redirected.”

The facility was a single-family home with an open-concept main floor, or one large room with common areas. VA1’s and VA2’s respective bedrooms were down short hallways on opposite sides of this room. There were bathrooms near each bedroom making it so VA1 and VA2 did not have to use the same bathroom.

The T provided the following information to this investigator and to a law enforcement officer (LEO):

- At the time of this investigation, the T had worked with VA1 for eight years at VA1’s school. VA1 was familiar with the T and talked about various things with him/her. According to the T, VA1 “loves” the facility and frequently declined to spend a weekend with his/her family in order to stay at the facility. VA1 did not like to “tell when things are wrong.” For example, if VA1 felt sick, s/he might not tell anyone out of fear of missing school. VA1 did not have a history of talking about romantic partners or dating.
- During September and October 2023, VA1 began experiencing increased itchiness in his/her genital area. This was “not a regular thing” for VA1. G1 was aware and sent special wipes to the school for VA1 to use in the bathroom.
- Around the end of September or early October 2023, VA1 began mentioning a specific staff person who worked at the facility. VA1 provided this staff person’s first name and said that s/he was going to “marry” the staff person someday. [Note: This staff person’s first name was the same as the SP’s first name. The facility did not employ any other staff persons with this same first name.]
- On October 17, 2023, a teaching assistant approached the T with concerns about VA1’s behavior. VA1

had been using the bathroom and was taking longer than expected. The teaching assistant peeked into the room and saw VA1 touching his/her own genitalia in a manner that appeared to be for sexual arousal. The teaching assistant immediately informed the T.

- According to the T, VA1 did not have a history of touching him/herself for sexual arousal at school. The T was concerned about this conduct along with the increased genital itchiness and discussions about marrying the SP and wanted to check-in with VA1.
- The T met with VA1 and asked him/her about life at the facility. VA1, unprovoked, told the T that the SP "sometimes ... sleeps with" VA2. VA1 was "worried" about what the SP "is doing to" VA2. According to the T, while speaking, VA1 had a look on his/her face, which the T had seen before when VA1 "doesn't want to tell you something."
- The T asked VA1 additional questions, including when the SP worked and what did they did together. VA1 told the T that the SP helped him/her in the shower. The T asked if the SP touched VA1's "private parts" in the shower and VA1 said, "Yes." VA1 told the T that no other staff persons helped him/her in the shower. The T was not aware of VA1 needing any help in the shower.
- VA1 told the T, "[The SP] sleeps with me and lays with me on my mattress." The SP was the only staff person who "lays with" VA1. When this happened, "[The SP] touches my breasts and rubs down there," "It feels good," and "I like [the SP]." VA1 also said, "[The SP] takes [the SP's] pants off" but "always" left his/her shirt on. The SP told VA1 not to tell anyone. [Note: The word "breast" was used by VA1; however, this word should not be used as an indicator of the gender and/or genitalia of VA1 or the SP.]
- The T asked VA1 to demonstrate what the SP did using a life-size skeleton, which happened to be in the room with them. VA1 put the skeleton's hand on VA1's upper chest area and genital area.
- VA1 told the T, "[The SP] gives me bad ideas and tells me not to tell anybody." The SP showed VA1 "things" on an iPad and told him/her not to tell anyone. The T did not ask VA1 what this entailed.
- The T asked VA1 yes or no questions to gather the aforementioned information. However, when VA1 answered "maybe" to some questions, and the T prompted him/her for a yes or no response, VA1 answered, "Yes."

A Red River Children's Advocacy Center Forensic Interview Report provided the following information:

- On October 18, 2023, VA1 was interviewed by a professional who specialized in interviewing children and vulnerable adults who were alleged to be victims of sexual abuse. VA1 discussed his/her likes and dislikes and friends at the facility.
- "[VA1] circled the parts of the body that are private- [s/he] circled [his/her] private, breasts, and butt." [Note: The word "breasts" was used in the *Red River Children's Advocacy Center Forensic Interview Report*; however, this word should not be used as an indicator of the gender and/or genitalia of VA1 or the SP.]

- “[VA1] discussed one staff member named [the SP’s first name]. [VA1] stated that [the SP] is very nice and [s/he] watches [VA1] play on [VA1’s] iPad. When questioned further about [the SP], [VA1] stated that [s/he] doesn’t want to talk about [the SP] anymore and doesn’t want to talk about the [facility] anymore.”

A Marshall County Sheriff’s Office report provided the following information:

- The LEO was present for, and watched from a different room, VA1’s forensic interview at the Red River Children’s Advocacy Center. According to the LEO, “[VA1] did say I don’t want to talk about [the SP] and became visibly upset and uncomfortable when talking about [the SP]. [VA1] would get uncomfortable and move around in [his/her] chair after mentioning [the SP]. It is believed [VA1] disclosed information to [the T] because [s/he] is comfortable with [the T] and has known [him/her] for years from school.”
- The LEO obtained a notebook (or journal) from G1, which included daily notes about VA1’s school activities.
- The LEO determined the following after reviewing the notebook:
 - “Some of the way [VA1] was acting started after [the SP] begun working at [the facility] in August of 2023.”
 - “On 9-20-2023, it is written in the notebook that [VA1] was complaining about [his/her] bottom hurting.” G1 told the LEO that VA1’s “bottom” referred to VA1’s genitalia. “[The SP] had worked that weekend before. [The SP] worked 9-15-2023 through 9-17-2023. [The SP] worked all weekend. When staff work all weekend at [the facility], they stay there the entire weekend.”
 - “On 10-5-2023 [VA1] didn’t eat [his/her] lunch at school and wasn’t [him/herself]. That is what was written in [VA1’s] journal from the school. [The SP] worked the day before on 10-4-2023. [G1] stated that [VA1] generally has a good appetite and will always eat.”
- The SP declined to be interviewed by the LEO.
- On October 18, 2023, a county attorney charged the SP with criminal sexual conduct-4th degree. [Note: At the completion of this investigation, court proceedings were pending.]

The P provided the following information:

- VA1 and VA2 were housemates but not close friends. VA2’s bedroom was at the end of a hallway and VA1’s bedroom was in a different hallway. For VA1 to see VA2 lying in bed, s/he would have to walk to the end of VA2’s hallway. There was a bathroom there but not one VA1 typically used. It was possible to see VA2’s bed from the hallway if his/her bedroom door was open.
- VA2 might need help covering him/herself with blankets when in bed. VA1 did not need any help when in bed. There was no reason why a staff person should be lying in bed with VA1 and/or VA2.
- VA2 needed help from staff in the shower. VA1 had started needing some help recently, at the time of this investigation, since s/he was experiencing genital itchiness. The P did not know if this was hand-over-

hand help, or just verbal guidance. There were no rules about which staff could help a housemate in the shower. If VA1 needed help, the SP or any other staff could do so.

- The SP worked at the facility between late August and early October 2023.
- The SP mainly worked the overnight shift, which was single staffed. The SP was supposed to check on the housemates twice throughout the night, typically around 12 midnight and 3 a.m. These checks should include peeking a head in the door to make sure the individual was still in bed. There was no reason to approach the bed or touch the individual sleeping.
- The SP was required to remain awake for certain portions of the night but could also sleep at various points. There was a staff bed in the living room for the overnight staff person.
- The SP sometimes picked up other shifts where s/he might work with another staff (or be double staffed). The P was not aware of any staff having concerns with the SP's conduct. The P, also, did not have prior concerns with the SP's conduct.
- The P was not aware of any changes to VA1's and/or VA2's behavior or demeanor during the timeframe the SP was employed.
- The P was not aware of VA1 having a history of intentionally providing inaccurate information to get a staff person in trouble. The P was not aware of any conflict in the house or reason why VA1 might want to get the SP in trouble.

G1 said that s/he had no concerns prior to this incident. VA1 "loves, loves" the facility. G1 did not notice any changes in VA1's behavior or demeanor to indicate something occurred.

G2 said, "[VA2] is so vulnerable. [VA2] wouldn't remember ... If something happened to [VA2], I don't know how we'd ever know based on [his/her] memory." VA2 had since moved out and into a memory care facility.

Facility documentation stated that the SP and the P received training on the Reporting of Maltreatment of Vulnerable Adults Act. The SP also received training on VA1's and VA2's respective support plans and support plan addendums. The P was not required to receive this training based on his/her position, but said that s/he typically read through the support plans.

Conclusion:

A. Maltreatment:

VA1 told the T that the SP removed the SP's pants, laid in bed with VA1, and touched VA1's upper chest and genitalia. VA1 stated, "It feels good," and "I like [the SP]." VA1 said the SP told VA1 not to tell anyone. VA1 also stated that the SP "sometimes ... sleeps with" VA2 and VA1 was "worried" about what the SP "is doing to" VA2.

The SP initially responded to this investigator's voicemail message but then did not respond to subsequent phone calls, letters, or emails requesting an interview and declined to interview with the LEO.

Although there were no direct witnesses to what happened, there were factors that supported VA1's account,

including the following:

- The SP worked at the facility between late August and early October 2023. The SP worked the overnight shift, which was single staffed.
- During September and October 2023, VA1 began experiencing increased itchiness in his/her genital area, which was “not a regular thing” for him/her.
- The *Marshall County Sheriff's Office* report stated, “On 9-20-2023, it is written in the notebook that [VA1] was complaining about [his/her] bottom hurting.” G1 told the LEO that VA1’s “bottom” referred to VA1’s genitalia. “[The SP] had worked that weekend before. [The SP] worked 9-15-2023 through 9-17-2023. [The SP] worked all weekend. When staff work all weekend at [the facility], they stay there the entire weekend.”
- Around the end of September or early October 2023, VA1 began mentioning the SP and that s/he was going to “marry” the SP someday.
- The *Marshall County Sheriff's Office* report stated, “On 10-5-2023 [VA1] didn't eat [his/her] lunch at school and wasn't [him/herself]. That is what was written in [VA1's] journal from the school. [The SP] worked the day before on 10-4-2023. [G1] stated that [VA1] generally has a good appetite and will always eat.”
- On October 17, 2023, a teaching assistance discovered VA1 touching his/her genitalia in what appeared to be for sexual pleasure, which was not common for VA1.
- On October 18, 2023, VA1 was interviewed by a professional who specialized in interviewing vulnerable adults who were alleged to be victims of sexual abuse. According to the LEO, who was watching the interview from a different room, “[VA1] did say I don't want to talk about [the SP] and became visibly upset and uncomfortable when talking about [the SP]. [VA1] would get uncomfortable and move around in [his/her] chair after mentioning [the SP].”
- Although VA1 did not disclose information during the interview, the LEO documented, “It is believed [VA1] disclosed information to [the T] because [s/he] is comfortable with [the T] and has known [him/her] for years from school.”

Given those factors and that VA1 did not have a history of intentionally providing inaccurate information to get others in trouble, it was determined that VA1’s account was credible. This included VA1’s account that the SP “sleeps with” VA2 and that VA1 was “worried” about what the SP “is doing to” VA2. The P provided information that there would be no reason for a staff person to lie in bed with VA2. Therefore, there was a preponderance of the evidence that the SP had sexual contact with VA1 and VA2.

It was determined that sexual abuse 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).

In addition, given that VA1 and VA2 each needed services and supports relating to their diagnoses, it was

reasonable that they might continue to need professional supports throughout their lives. The SP's interactions with VA1 and VA2 likely hindered their ability to have a consistent understanding of the parameters of a therapeutic relationship which could interfere with other individuals' attempts to provide therapeutic services, both now and in the future. Therefore, there was a preponderance of the evidence the SP's interactions with VA1 and VA2 were detrimental to their ongoing mental health and were a failure to provide reasonable and necessary care or services.

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

B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):

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

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

The SP was responsible for the care and supervision of VA1 and VA2. The SP received training on VA1's and VA2's respective support plans and support plan addendums and on the Reporting of Maltreatment of Vulnerable Adults Act.

The SP was responsible for maltreatment of VA1 and VA2.

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 sexual abuse and neglect for which the SP was responsible was “recurring and serious” maltreatment. The SP was responsible for more than one incident of sexual abuse of VA1 and VA2.

The SP was disqualified from providing direct contact services.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate and followed. The SP was not allowed access to the facility or housemates until the investigation was completed.

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.

Administrative Reconsideration:

The disposition of the investigation is amended from the SP is responsible for maltreatment by sexual abuse and neglect of VA1 and VA2, to the SP is responsible for maltreatment by sexual abuse of VA1 and not responsible for

maltreatment by sexual abuse of VA2 or maltreatment by neglect of VA1 or VA2. To the extent the language in the Administrative Reconsideration conflicts with the language in the remaining part of the Amended Investigative Memorandum, the language in the Administrative Reconsideration controls. The disposition was amended based on the following:

Amended Summary of Findings:

Amended Responsibility for Sexual Abuse of VA2:

Upon further legal review, it was determined that there was not a preponderance of evidence whether SP was responsible for maltreatment by sexual abuse for VA2. The allegation regarding VA2 lacked specificity and detail. Further, VA2 did not provide an account of any such conduct due to his/her vulnerabilities.

Amended Responsibility for Neglect of VA1 and VA2:

Upon further legal review, it was determined that there was not a preponderance of evidence whether the SP was responsible for maltreatment by neglect of VA1 and VA2. Pursuant to Minnesota Statutes, section 626.5572, subdivision 17, paragraph (a), neglect means 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. The available information does not show by a preponderance of the evidence that either VA1 or VA2 were neglected. There are no allegations that either individual did not receive necessary care or services.

Amended Conclusion:

It was determined that the SP was responsible for maltreatment by sexual abuse of VA1. It was not determined that the SP was responsible for maltreatment by sexual abuse of VA2 or neglect of VA1 and VA2.

The SP was responsible for serious maltreatment of VA1. There was insufficient information to find that SP is responsible for recurring maltreatment.

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

On April 16, 2025, the SP was notified that s/he was no longer responsible for maltreatment by sexual abuse of VA2 and longer responsible for maltreatment by neglect of VA1 and VA2. The SP was notified that the finding of maltreatment by sexual abuse of VA1 was affirmed and that the sexual abuse of VA1 was serious maltreatment. The SP remained disqualified.