

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: 202508098

Date Issued: November 20, 2025

Name and Address of Facility Investigated:

Disposition: Substantiated as to sexual abuse of a vulnerable adult by a staff person

Alongside Services II
2681 Nightingale Court
Chaska, MN 55318

Alongside Services II
204 Lewis Ave S Ste 103
Watertown, MN 55388

License Number and Program Type:

1068735-H_CRS (Home and Community-Based Services-Community Residential Setting)
1068731-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
Licensing Division
PO Box 64242
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) touched a vulnerable adult's (VA) genitals.

Date of Incident(s): Unknown dates in summer 2025, prior to September 2, 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 was obtained during a site visit conducted on September 25, 2025; from documentation at the facility, law enforcement records; and through six interviews conducted with a supervisory facility staff person (P1), a facility staff person (P2), the VA's guardians who were also family members (G1 and G2), and a client (C). This investigator met with but did not interview the VA, however the VA provided information to law enforcement. The SP was offered an interview by this investigator and refused; however, law enforcement conducted an interview with the SP and that information was included below.

The VA lived at the facility with three other clients. The facility was split-level with the VA's bedroom on the lower level and the staff office located in a bedroom part-way down the hallway on the upper level. A security camera was positioned on the kitchen wall, pointing down the hallway toward the staff person office and in the lower level, outside of the VA's bedroom. The staff person office had a curtain hanging in the doorway and a full-sized bed for the overnight staff person to sleep in.

The VA was diagnosed with reactive attachment disorder, post-traumatic stress disorder, and mild intellectual impairment. The VA sometimes had "boundary issues" with staff persons of the opposite gender.

The VA enjoyed watching movies, playing games, doing puzzles and completing diamond art.

P1, P2, and the C, provided the following information:

- The C stated that on the evening of September 1, 2025, the VA entered the C's bedroom and said that on more than one occasion, the SP touched the VA underneath his/her clothes on the VA's genitals using the SP's hand. It happened twice during the overnight shifts in the staff office when other clients were sleeping. The most recent time, the SP wore a glove. The VA told the C that it had occurred about three to four weeks ago. The VA seemed "okay" and "acted normal" when telling the C.
- On September 2, 2025, the C told P2 about the incident with the VA and the SP and P2 immediately told P1. P1 arrived at the facility that day to talk to the VA and the SP, who was scheduled to work.
- P1 stated that the VA initially did not want to talk about the incident, but shortly thereafter, told P1 that "it happened" two times and started in summer 2025, but could not provide exact dates. The VA had a "crush" on the SP and did not want to get the SP "in trouble."
- According to P1, shortly thereafter, when asked, the SP denied any "inappropriate boundaries" with any clients at the facility. P1 asked the SP to leave the facility and placed the SP on a suspension. The SP left

the facility between 3 and 3:30 p.m. At 5:32 p.m., the SP texted P1 and said, "Hello I wanna confess that it happened." The SP then texted that it happened twice and that s/he did not know the dates. The SP also apologized for not, "reporting it sooner," and texted, "I wasn't into it."

- P1 stated that the overnight staff person typically worked alone, and that the SP worked fifteen overnight shifts since starting at the facility in late 2024. Clients were not to be in the staff person office.
- P1 stated that the SP worked the overnights on August 10, 15, 16, 27, and 31, 2025. Overnight shifts were scheduled to start at 10:30 p.m. and went until about 9 a.m. The VA typically went to bed later, between 10 to 11 p.m. Generally, the C was the only other client that was awake at that time, but the VA did not have to pass the C's doorway to get upstairs. P2 stated that the VA was "a night owl."
- P2 spoke with the VA several weeks later and the VA stated that sexual contact with the SP happened four times.

The VA provided the following information:

- The VA and the SP began to "like each other" but the VA knew it could not go further. One night, the VA went into the staff person office to tell the SP goodnight, and the SP patted the bed and told the VA to "come here." The SP asked the VA if s/he wanted to "do it." The SP and the VA laid down on the bed and the SP touched the VA underneath his/her clothing on his/her genitals.
- This happened four times and the same thing happened each time. The final time, the SP wore a glove and told the VA it was because s/he did not want to "hurt" the VA. This time, the SP "overdid" it, which caused the VA to bleed. The VA was not seen by a medical professional afterward.

G1 provided information consistent with P1, P2, the C, and the VA, and provided the following information:

- Sometimes the VA left out details, so G1 asked the VA for additional details and the VA stated that the sexual touching happened four different times while the SP worked overnights. The VA told G1 that no other sexual touch happened beyond what had already been described.
- The VA thought that s/he was in a relationship with the SP.

Information from law enforcement showed that the SP admitted to "sexual" touch of the VA's genitals under the VA's clothing, with the SP's hand, but did not know how "it happened." The VA came to the staff person office one evening, and they sat on the bed. The SP then touched the VA's genitals with his/her hand under the VA's clothing and stated that it happened twice. The SP was arrested and charged with Criminal Sexual Conduct.

G2 stated that on September 2, 2025, P1 notified G2 that there was possibly some "inappropriate touching" by the SP including "finger penetration" to the VA. G2 had not spoken with the VA since the incident and did not have any other information to provide.

All staff persons interviewed for this investigation were trained on the VA's plans and the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

A. Maltreatment:

Information from P1, P2, the C, the VA, the SP, and G1 was consistent that the SP touched the VA's genitals, under his/her clothing, on at least two occasions, during overnight shifts when the SP worked. The VA told law enforcement, P2, and G1 that it happened four times and that it happened in summer 2025, but not in September 2025.

Given that information was consistent, and that the SP stated that s/he touched the VA's genitals on two occasions, there was a preponderance of the evidence that the SP had sexual contact with the VA.

In addition, the SP's interactions with the VA hindered the VA's ability to have a consistent understanding of the parameters of a therapeutic relationship which could interfere with other individuals' attempts to provide therapeutic services to the VA both now and in the future. Therefore, there was a preponderance of the evidence that the SP failed to maintain professional boundaries and that the SP's interactions with the VA were detrimental to the VA's ongoing mental health and a failure to provide reasonable and necessary care and services.

It was determined that sexual abuse and 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 and 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 trained on 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 sexual abuse that the SP was responsible for was recurring and serious maltreatment because the SP had sexual contact with the VA on more than one occasion and because it met the definition of serious maltreatment.

It was determined that the substantiated neglect that the SP was responsible for was not recurring maltreatment because it was a single pattern of behavior but was serious maltreatment because the SP was charged with criminal sexual conduct.

The SP was disqualified from providing direct contact services.

Action Taken by Facility:

The facility's *Internal Review* stated that policies and procedures were adequate but not followed. Staff persons were retrained on boundaries with clients and 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.