DEPARTMENT OF HUMAN SERVICES

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: 202510775

Date Issued: January 7, 2026

Name and Address of Facility Investigated:

LSS Bartlett
11995 Main Street
Northome, MN 56661

Lutheran Social Services of Minnesota
2485 Como Avenue
Saint Paul, MN 55108

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

License Number and Program Type:

1077960-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069963-HCBS (Home and Community-Based Services)

Investigator(s):

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Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

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

Date of Incident(s): November 15, 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):

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.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on December 3, 2025; from documentation at the facility and law enforcement records; and through interviews conducted with a facility supervisor (the P). The VA and the SP provided information in law enforcement records, and that information was included below. This investigator met the VA at his/her residence on the date of the site visit. Two letters, one certified, were sent to the SP requesting an interview with this investigator, but the SP did not respond to the letters. According to a law enforcement officer (the LEO), the SP declined an interview with this investigator.

Facility documentation and the VA's *Individual Abuse Prevention Plan* (*IAPP*) showed that the VA had a developmental disability and was vulnerable to all forms of maltreatment. The VA lacked understanding regarding sexual relationships, was likely to cooperate in an abusive situation, and was unassertive. The VA was friendly to everyone including strangers and did not identify aggressive persons or dangerous situations. Staff persons were to assist the VA with balance when s/he walked by using a gait belt they placed around the VA's waist because the VA might trip or bump into stationary objects. The VA's *Intensive Support Self-Management Assessment* stated that the VA would probably tell staff persons if something upset him/her. The VA was kind, took pride in his/her appearance, and enjoyed meeting others.

Interviews with this investigator, facility documentation, the facility's *Internal Review*, and information from the law enforcement agency provided the following:

- The VA said that on the evening of November 15, 2025, the SP got into bed with the VA, kissed the VA's chest and touched the VA's chest with his/her hands, then placed his/her hand inside the VA's clothing and touched the VA's genitals. The VA told the SP, "No," and pushed the SP's hands away. The incident lasted about two minutes, and the SP did not say anything to the VA during the incident. The next day, the VA told several staff persons about the incident.

- A video recording with audio of a forensic interview with the VA was reviewed by this investigator. During the interview, the VA said that the SP kissed the VA's chest and put his/her hands under the VA's clothing and touched the VA's genitals.

- The law enforcement agency sent information regarding their investigation of the incident to the county attorney's office for possible charges against the SP.

- The P, a supervisory staff person, stated that the VA provided consistent information to him/her and other staff persons over time regarding the SP's actions. According to the P, the VA maintained that on the date of the incident, the SP assisted the VA to use the bathroom and helped the VA walk into his/her bedroom. The VA lay in his/her bed to sleep, then the SP got into the bed with the VA, touched the VA's chest, put his/her hand inside the VA's pants, then touched the VA's "private parts." The VA did not have a history of providing inaccurate information, and the P believed him/her.

- The P added that there were three other individuals who resided at the facility with the VA, but there were no concerns regarding their safety and no information showed that the individuals were aware of the incident.

The facility's personnel and training records showed that the P and the SP were trained on the Reporting of Maltreatment of Vulnerable Adults Act and the facility's policies and procedures prior to the incident.

Conclusion:

A. Maltreatment:

The VA provided information to a law enforcement agency and in a forensic interview that on November 15, 2025, the SP touched and kissed the VA's chest, and touched the VA's genitals. The P said that the VA provided consistent information over time regarding the incident to several staff persons and did not have a history of providing inaccurate information.

The SP did not respond to this investigator's letters requesting an interview, and the SP declined to be interviewed according to the LEO.

The law enforcement agency investigated the allegations in this report and sent information from their investigation to the county attorney's office for possible charges against the SP.

Given that the VA provided consistent information about the incident and had no history of providing inaccurate information, there was a preponderance of the evidence that the SP had sexual contact with the VA.

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).

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 facility's policies and procedures 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 abuse for which the SP was responsible was not recurring because it was a single incident; however, it was serious maltreatment because the SP had sexual contact with the VA.

Action Taken by Facility:

The facility completed an *Internal Review* which determined that their policies and procedures were adequate but were not followed. As soon as the facility became aware of the allegations, the SP was suspended and had no further contact with the VA or individuals at the facility. At the time this report was written, the SP was no longer employed at the facility.

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

The SP was notified that s/he was responsible for serious maltreatment and that any future background studies for facilities, 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, will result in his/her disqualification. The determination that the SP was responsible for maltreatment is subject to appeal.