

MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 260E.01, paragraph (a), "The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment."

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: 202506302

Date Issued: January 16, 2026

Name and Address of Facility Investigated:

Wings
1326 E Ripley
Litchfield, MN 55355

Disposition: Maltreatment
determined/substantiated as to sexual abuse of
two alleged victims and neglect of twelve alleged
victims by a staff person.

License Number and Program Type:

1047343-CRF (Children's Residential Facility)

Investigator(s):

Lindsay Arth
Minnesota Department of Human Services
Office of Inspector General, Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
Lindsay.Arth@state.mn.us
651-431-6537

Suspected Maltreatment Reported:

It was reported that there were multiple concerns with a staff person's (SP's) interactions with an alleged victim (AV) including that the SP slapped the AV on his/her buttocks, massaged the AV's shoulders, added the AV on social media, and offered the AV a nicotine vape. Additionally, during the course of the investigation, there were concerns that the SP interacted with the majority of the clients in a similar manner.

Date of Incident(s): Unknown dates between June 24 and July 15, 2025

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 20; and

subdivision 15, paragraph (a), clauses (1) and (2):

"Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, or by a person in a current or recent position of authority to any act that constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse includes threatened sexual abuse.

Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so.

Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.

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 July 31, 2025; from documentation at the facility and law enforcement records; and through nine interviews conducted with the AV, two facility supervisory staff persons (P1 and P2), a staff person (SP), three facility clients (C1, C2, and C3), the AV's case manager (CM), and the AV's guardian (G).

The facility provided residential care for adolescents who needed treatment for chemical and mental health concerns. The facility was divided into two residential units, one for each gender, and had a total of 20 clients. Each residential unit had bedrooms, a living room, and bathrooms. Additionally, there were common areas throughout the facility that both units shared and there were cameras within the common areas. Facility documentation showed that there was one staff person per 12 clients, including while on outings. The clients involved in this report ranged in age between 13 and 18 years old.

The AV's plans showed that the AV began receiving services from the facility on April 28, 2025. The AV enjoyed art. The AV was diagnosed with anxiety, depression, nicotine dependence, and autism. The AV also had a history of "vaping every day." The AV denied any sexual, boundary, or "impulsivity" concerns. The AV's *Individual Treatment Plan* said that the AV had "cravings for nicotine occasionally" and staff persons were to assist the AV with engaging at least one new coping skill weekly when the AV experienced "cravings" or "high anxiety."

Facility information showed that the SP began working at the facility on June 22, 2025. The SP worked on both units.

The CM provided the following information:

- On July 15, 2025, the AV “successfully discharged” from the facility. On that date, around 4 p.m., the CM received a phone call from P1 stating that s/he found out earlier that day that the SP had been “inappropriate” with a “couple” of clients, including the AV. This included the SP “slapping” clients on their buttocks and that the SP gave the clients his/her social media information.
- On July 16, 2025, the CM spoke to the G about the concerns. The G told the CM that the AV told him/her that on July 4, 2025, the SP offered some of the clients, including the AV, a “nicotine vape” and also “pulled” the AV onto his/her lap and massaged the AV’s shoulders. The G said that the SP also told the AV that s/he was his/her “spirit person” and “mini me.” Additionally, the G said that the SP took photos of some of the clients while at a nearby beach, but the CM did not know additional information about this.
- The AV was an accurate reporter of information and was “very honest and upfront.”
- The CM did not observe any concerns with staff persons interactions when s/he was at the facility. However, the CM said that staff persons were “very affectionate” in general including hugging the AV at discharge.

The AV provided the following information:

- On July 4, 2025, the SP took “all” of the clients on the AV’s unit, including the AV and two additional clients (C10 and C11), to a nearby beach. The SP was the only staff person and at some point, the SP wanted to “take a break” and use his/her nicotine vape. While the SP was using his/her nicotine vape, the AV looked towards the SP and saw “every” client taking a “hit” from the SP’s vape and then the AV also “took a hit,” which the AV and other clients thought was “cool.”
- After July 4, 2025, the SP brought his/her vape to the facility each time s/he worked and let “every” client at the facility use it, including the AV. The AV used it approximately four times total, including on July 4, 2025, while at the beach. The SP gave it to the clients in their bedrooms and no staff person was aware that the SP did so. There were no times that the AV or other clients became sick because of using the vape. However, the AV worried that s/he or the other clients would “get in trouble” due to using the SP’s vape.
- On July 4, 2025, the SP also took photos of the clients at the beach and told the clients, including the AV, that s/he would send the photos to them via Snapchat. The AV said that some of the photos included C10 and C11, near a volleyball net at the beach, bent over and that C10, C11, and other clients had their hands on one another’s “butts [while wearing swimsuits].” The AV said that both the SP and the clients came up with the poses. The AV was not in those photos but saw the SP taking the pictures. After the AV discharged from the facility, s/he saw that the SP “tried” to add him/her on Snapchat. However, the AV “did not add [the SP] back.”
- Additionally, while at the beach, the SP showed “all” the client’s photos from the SP’s phone, including a photo of the SP in his/her undergarments. The AV felt “uncomfortable” when s/he saw this.
- At some point, a client, who the AV thought may have been C10 but who the AV did not recall for sure, told the AV that the SP “slapped” him/her on the buttocks. The clients gave staff persons nicknames and because of the SP “slapping” a client on the buttocks, the clients called the SP “[name of the SP] slap a

hoe." The SP never slapped the AV on his/her buttocks. The SP did not have nicknames for the clients, including the AV.

- Additionally, at some point after July 4, 2025, the AV, the SP, and other clients were at a local gym when the SP told the AV about a type of massage that the AV was not familiar with. Because the AV did not know what the massage was, the SP showed the AV by having the AV sit on the SP's lap and the SP massaged the AV's shoulders. The AV said that this made him/her "uncomfortable." There were no other times that the SP touched the AV.

The G provided the following information:

- On July 11 or 12, 2025, the AV told the G that the SP had him/her sit on the SP's lap and that the SP gave the AV a massage. The AV also told the G that on July 4, 2025, the SP "passed around a vape" and that the SP continued to do so "frequently" after that, including while on a walk or in client's bedrooms. The AV told the G that s/he used the vape on July 4, 2025, along with "all" the clients but did not use it after.
- The G said that the SP also "requested" the AV on Snapchat, but the AV did not "accept." The AV did not have any of the photos that the SP took at the beach.
- The G never saw any concerns while s/he was at the facility. However, the SP took a "special liking" to the AV and at some point, made a "point" to "introduce" him/herself to the G. The SP told the G that the AV was his/her "mini me" and that the SP felt "very attached" to the AV which the G said was a "little weird."

C1, C2, C3, and the *Internal Review* provided the following information:

- C1 said that on July 4, 2025, the SP, C1, and some of the other clients were at a nearby beach. At some point, the SP "offered" the clients, including C1, his/her "nicotine vape." C1 was "surprised" because this was the first time a staff person had offered the clients a vape. C1 said that some of the clients, including C1, used the vape.
- C1 said that after July 4, 2025, the SP offered C1 his/her vape in places within the facility without cameras, including client bedrooms. C1 used the SP's vape a "couple times" but also said that s/he "did not know how many times" but that it was "almost" every time that the SP worked. According to C1, the SP "fed" the clients their "addiction" by offering them his/her vape. Additionally, using the SP's vape made C1's "withdrawals" from nicotine, "worse." Prior to the SP offering C1 the nicotine vape, C1 said that his/her "withdrawals" from nicotine had "calmed down." C1 also said that a client (C8) was "addicted" to nicotine and C8 always asked C1 to ask the SP to use the vape which made C1 "mad." C1 said that the SP did not ask the clients for anything when they used the SP's vape. However, the SP said that s/he was "doing this" for the clients and that they "better not act up" or "snitch."
- A client (C6) said that at some point, s/he "noticed" the SP's nicotine vape in the SP's pocket. C6 asked the SP to use it, and the SP "allowed" C6 to use it "twice," both times in C6's bedroom.
- C2 and C3 said that they never saw the SP give clients vapes but "heard" other clients talk about it.

Additionally, C2 and C3 each said that at some point, C3 "joked" and asked the SP to use his/her vape but the SP said that s/he "did not have it right now."

- C1 stated that C8, and two clients (C4 and C9), on July 4, 2025, while at the beach, the SP took "sexy" or "provocative" photos and/or videos of the clients in their swimsuits, including C10. This included the SP "directing" the clients to "pose" by "grabbing" one another's "butts" and chest and to also "bend down" with their "butts out." A facility client (C5) also said that the SP had photos and videos of the clients "moving their bodies in provocative ways." C1 said that the SP saved the photos and videos to his/her Snapchat "memories." However, according to C4, the SP said that if supervisory staff persons found out, s/he would "just delete Snapchat."
- C3 said that on July 4, 2025, while at a parade, the SP took a couple photos of the clients in groups but that they were not sexual in nature. C2 was not aware of the SP taking inappropriate photos of the clients.
- C1 and C8 also said that on unknown dates, the SP used an open hand to "pat" them and other clients on the face, arms, legs, feet, and buttocks, over their clothing. C1 and C8 each said that the SP "jumped" or sat on the clients, including C8. C8 said that the SP lay on top of him/her when C8 was in another client's bed because the SP was "trying to be funny." C8 also said that the SP lay on top of clients while at the beach. C1 said that the SP would "twerk on [the clients]," which C1 said was "really weird." C1 also said that the SP had the AV sit on his/her lap. C3 was not aware of the SP inappropriately touching the clients.
- C1 said that the SP made inappropriate comments about the client's bodies including that their "butts" and "bodies" were "big." Additionally, at some point, the SP told C1 that s/he wanted to "smack" C1's "butt." C2, C3, and a client (C7) said that the SP called C7 "big booty [name of C7]." C3 said that the SP did so because other clients called C7 that. C1 and C5 said that the SP called the clients his/her "little whores."
- At some point, C1 asked the SP to smell his/her yoga mat because it smelled like "bonfire" and asked the SP for help cleaning it and the SP said, "No. It probably has your [derogatory name of genital area] juice all of it." The SP said this in front of other clients which "embarrassed" C1.
- C9 said that the SP made "sexual jokes" about acquired immunodeficiency syndrome (AIDS) and also said that s/he had a "lot of hoes on [his/her] phone." C6 and C7 each said that the SP "disclosed inappropriate" romantic and personal relationship information with them, including about his/her "sexual partners." C7 said that the SP sang "inappropriate songs" which "glorified" drugs, sex, and violence. C9 said that the SP sprayed body fragrance on items in the client's living areas so that the clients would "remember" the SP. C9 said that the SP asked C9 to braid his/her hair on two occasions. Additionally, C1 said that the SP also danced "provocatively," including "shaking" his/her buttocks. C4 also said that the SP also "offered" for C4 to live with him/her once C4 graduated from the facility and that C4 could rent out a space in the SP's home.
- C3 "felt" that the SP "flirted" with him/her and C3 and C6 each stated that the SP asked C3 "multiple" times why s/he did not have a significant other and said that C3 "looked good." Additionally, the SP made comments including telling C3 which clients s/he thought were "hot" and that s/he "bet" some of the clients "had more bodies [sexual partners]" than the SP. The SP also told C3 that s/he had "more" sexual partners, which the SP told C3 was "more than 14," than C3. C3 said that the SP's interactions did not

make him/her uncomfortable.

- C1 said that on July 4, 2025, while at the beach, the SP also showed the clients photos of him/herself posing “provocatively” in undergarments on his/her personal cell phone. C1 also said that the SP’s nickname for him/herself was “[name of the SP] smack a hoe.” According to C1, the SP treated the clients like they were the SP’s “adult friends.”
- C1 and C9 also said that the SP added the clients, including C1, on Snapchat or asked the clients to add the SP on Snapchat once they left the facility. C9 said that the SP wanted to add the clients on Snapchat so that the SP could send the clients the photos the SP took of them at the beach. However, C1 did not have access to his/her phone while at the facility so had not communicated with the SP via Snapchat but said that once s/he access to his/her phone, s/he planned to hit “ignore” on the SP’s request for Snapchat. C2 and C3 said that the SP never asked them for their social medial information.
- C1 said that the SP interacted in the aforementioned manner with the majority of the clients on his/her unit. C1 initially did not think “much” of the SP’s interactions but said that the SP’s interactions got “weirder” as the days went on and C1 became “uncomfortable.” C1 said that s/he and the other clients were “too scared to speak up” and tell other staff persons about the SP’s interactions.
- The clients each denied showing or being asked to show the SP their genital areas and denied any sexual intercourse with the SP.
- P2, P4, and a staff person (P3) provided information in the internal review that they did not “witness” any concerns with the SP, including regarding the vapes or any “misconduct.”
- The facility also reviewed video footage from July 4, 2025, which showed the SP entering the client’s bathroom with clients and “emerging” with his/her hair braided. Additional footage also showed that the SP “violated physical boundaries” with clients by assisting them with their hair and makeup. Video footage also showed that on July 5, 2025, the SP entered client’s bedrooms and went “off camera;” that the SP “touched” the AV’s shoulder; and that the SP “rubbed” C9’s lower leg.
- The facility reviewed client urinalysis from various dates which showed that “all” clients tested negative for nicotine except the clients who were prescribed nicotine replacement therapy, including C1. [Note: According to Webmd.com, “generally, nicotine will leave your blood withing 1 to 3 days after you stop using tobacco.”]

P1 and P2 provided the following information:

- On July 14, 2025, P2 overheard some clients talking about “vaping” with nicotine vapes. On July 15, 2025, P1 and P2 spoke to C1, C4, C5, C8, and C9 about the “vaping” who said that the SP “provided” nicotine vapes to all the clients on the AV’s unit except the AV, starting on July 4, 2025. C1, C4, C5, C8, and C9 each said that the SP did this in places where it was “hard” for the SP to get “caught” including off property, at a nearby beach, in client bedrooms, or places within the facility without cameras. The SP also did this on the evening and weekend shifts when no “management” was at the facility.
- C1, C4, C5, C8, and C9 also brought up additional concerns including that the SP added the clients on

Snapchat. They also said that the SP took "provocative" photos of the clients at the beach, including the clients "grabbing" their chest area outside of their shirt, photos of the clients "bending over," and the clients "twerking" or dancing "provocatively." P1 and P2 never saw these photos or videos.

- The clients also told P1 and P2 that the SP had "creepy" or "inappropriate" interactions with them including telling them that they were "attractive" and asking them why they did not have significant others. The SP also talked about his/her personal life including how many people s/he "slept with."
- At some point a parent, who P1 did not recall, said that his/her child had a "friend request" from the SP on Snapchat, which staff persons were trained not to do. P2 said that his/her family member was friends with the SP on Snapchat and did not see the SP posting photos or videos of the clients.
- P2 said that the AV's "whole wing" was affected by the SP's interactions.
- P2 then reviewed video footage from a "few" of the SP's shifts but did not see anything "inappropriate." However, the SP went into client bedrooms and shut the door, which was "against [facility] policy." On one of these occasions that the SP shut the door, video footage showed that P3 was also present so P2 asked P3 about this. P3 told P2 that s/he thought it was "okay" at the time because the SP was "deescalating" a client. P2 also observed the SP go into the bathroom with clients and the SP came out with a different hairstyle. Staff persons were trained not to go into bathrooms with clients. The SP was also observed on the camera touching the clients "in general" such as on their shoulder which P1 and P2 each said staff persons were trained "not" to do. The SP was also on his/her phone in front of the clients which was against the facility policy.
- P2 spoke to the SP who said that s/he "never" brought vapes into the facility. Additionally, at some point prior to becoming aware of the concerns with the vapes, P1 and P2 said that the G told them that the SP had "rubbed" the AV's shoulders so P1 and P2 spoke to the SP who was "very shocked" and said that s/he touched the AV's shoulders for a "few seconds" to show the AV a "massage" but would "never do that again."
- P1 described the SP as "happy and bubbly." P1 and P2 saw the SP interact with the clients at times and did not see anything "inappropriate." However, P1 and P2 were also not aware of any reason why the clients would say these things if they were not true and said that all of their concerns were "spot on" and similar. At times, clients would "get staff in trouble" but did so with staff persons they did not like and the clients liked the SP.
- P2 trained the SP prior to the incidents, including that staff persons were to have "absolutely no" touching with a client unless it was a medical reason, that staff persons were not to add the clients on social media, and that staff persons needed to leave their vapes in their car or use it off property.

Law enforcement did a "search warrant" on the SP's Snapchat and did not see any photos or videos of the clients. Law enforcement also saw videos of fireworks on July 4, 2025, but did not see any of the clients. Law enforcement did not see any indication that the SP was friends with the clients on Snapchat but said that it was "possible" that this was because the clients did not "accept" the SP's friend request. Law enforcement did not take any further action.

The SP provided the following information:

- The SP was “shocked” when s/he heard about the concerns and said that s/he would “never” harm any of the clients, including letting them vape. The SP was trained not to give clients vapes because they were at the facility for “drug addiction” and their mental health. The SP had a vape but did not use it at work. However, the clients knew that the SP had a vape because the facility parking lot where the SP parked was also where the clients hung out, including to play basketball, and they saw it in the SP’s car. Additionally, staff persons would vape across the street from the facility which the clients could see.
- The SP had Snapchat but said that staff persons were not “allowed” to add clients on social media and the SP denied adding the clients on social media. The SP initially said s/he was not aware of any clients adding him/her on Snapchat but later said that during the interview with this investigator, s/he looked at his/her Snapchat and saw that the AV “tried” to add him/her on Snapchat but did not know when the AV had done so. The SP did not “accept” the AV’s friend request and the AV and the SP never communicated via Snapchat. The SP was not aware of any other clients adding him/her on Snapchat.
- Sometimes the clients took staff persons phones and took photos but the SP was not aware of any clients doing that with his/her phone. The SP denied showing photos of him/herself to the clients, including in provocative clothing. The SP was trained not to take pictures of the clients and denied taking pictures of the clients, including while at the beach. The SP said that s/he would “never” take photos of “underage” children “without permission” from their parents.
- The SP denied calling the clients by anything other than their name and denied calling any client by a nickname. The SP denied telling clients they were attractive or commenting about their looks. The SP denied talking to the clients about “personal” things.
- The SP said s/he only touched one client, C4 when C4 had a seizure. The SP denied giving clients massages, having them sit on his/her lap, or slapping them on their buttocks. However, the clients touched one another and staff persons “all the time.”
- The SP thought that the clients said that the SP did the aforementioned things because the SP was “new” and “followed the rules” and the clients were “vulnerable” and in “crisis” and would do “anything” to get staff persons in trouble.
- The SP was concerned that staff persons were often single staffed during outings, including due to the “allegations” and not having another staff person to be a witness and because it was difficult if a staff person need to assist a client or use the restroom.

The *General Staff Specific Rules* said that clients were never shown anything on staff persons personal cell phones and that clients should “never” see staff persons phones. Staff persons were prohibited from use of nicotine of any kind at the facility, including vaping. Staff persons were prohibited from distributing any form of nicotine to the clients. Staff persons were prohibited from touching clients and staff persons were not to let the clients touch them. Staff persons were not to share personal information with the clients. Staff persons and clients were not to communicate on “online platforms” and were to immediately notify their supervisor if this occurred.

The *Wings Code of Ethics and Practice* said that staff persons were not allowed to engage in sexual or romantic relationships with past or current clients. The *Program Abuse Prevention Plan* said that staff persons were not “allowed” to take photos or videos with their phones. Staff persons were not allowed to show their personal

phones to client.

Facility documentation showed that the SP, P1, and P2 received training on facility policies and procedures including the Program Abuse Prevention Plan, the Wings Code of Ethics and Practice, and on the Reporting of Maltreatment of Minors Act.

Relevant Statute:

Minnesota Statutes, section 609.341 defines "intimate parts" as including the primary genital area, groin, inner thigh, buttocks, or breast of a human being; and defined "sexual contact" as including the touching by the complainant of the actor's, the complainants, or another's intimate parts effected by a person in a current or recent position of authority. In any of the cases, this included the touching of the clothing covering the immediate area of the intimate parts.

Minnesota Statutes, section 609.685, subdivision 1a, paragraph (a) states in part that it is illegal for any person 21 years of age or older to sell, give, or otherwise furnish tobacco, tobacco-related devices, or electronic delivery devices to a person under the age of 21 years.

Minnesota Statutes, section 609.6855, subdivision 1, paragraph (a) states in part that it is illegal for any person 21 years of age or older to sell, give, or otherwise furnish to a person under the age of 21 years a product containing or delivering nicotine, whether natural or synthetic, intended for human consumption, or any part of such a product.

Conclusion:

A. Maltreatment:

There were multiple concerns with the SP's interactions with the AV and other clients that started on July 4, 2025, and continuing thereafter.

Although the SP denied letting the clients use his/her vape, information from all other sources was consistent that the SP let the AV and additional clients including C1, C4, C5, C6, C8, and C9 use his/her vape, which given that none were over the age of 21 was illegal and encouraged each to participate in illegal activities. The AV also said that the SP allowed "all" the clients to use his/her vape, however, C2 and C3 each denied using the SP's vape but saw other clients doing so. Additionally, although there was no video footage, information was consistent from the clients that the SP let the clients use his/her vape in places off site or away from the cameras such as in client bedrooms.

There were also concerns that the SP added or attempted to add clients on Snapchat, including the AV and C1. Law enforcement did a search warrant on the SP's phone and did not see any indication that the SP was friends with clients on Snapchat but said that may have been because none of the clients "accepted" the SP's friend request. The SP denied adding any of the clients on Snapchat and initially told this investigator that s/he was not friends with any of the clients but later said that the AV "tried" to add him/her but that s/he did not accept the AV's friend request.

Information from the clients also showed that the SP talked about or showed clients, including the AV and C1,

personal information about him/herself including “provocative” photos in the SP’s undergarments and talking about the SP’s sexual history. There was also information that the SP also took “provocative” photos of clients, including C10 and C11, while at the beach. However, no staff person saw these photos and this investigator and law enforcement were not able to locate these photos.

C1 and C8 also said that on unknown dates, the SP used an open hand to “pat” them and other clients on the face, arms, legs, feet, and buttocks, over their clothing. Additionally, at some point, the SP told C1 that s/he wanted to “smack” his/her “butt.” The AV also said that the SP rubbed his/her shoulders. The SP denied touching the clients in any manner, including on their buttocks and no staff person saw the SP touching clients on their buttocks.

Regarding Neglect

Although the SP denied the allegations, the SP had reason to minimize his/her actions for fear of repercussions and there was no information provided to discredit the accounts of the incidents provided by the AV and C1-C9. In addition, the AV and C1-C9 each provided similar information regarding the SP’s interactions and the CM described the AV as “very honest and upfront.” Therefore, it was more likely that the SP engaged in the interaction as described by the AV and C1-C9.

The AV and C1-C11 (in addition to other clients that the SP likely interacted with during his/her employment) were each at the facility for support regarding their substance abuse and mental health disorders and the AV’s Individual Treatment Plan stated that staff persons were to assist the AV in engaging in at least one new coping skill weekly, so it was reasonable that the AV and C1-C11 would likely continue to need supports to develop and maintain the necessary life and social skills to maintain and build healthy relationships. The SP’s interactions with the AV and C1-C11, who were all adolescents, 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 to each both now and in the future and encouraged each to engage in illegal activity by smoking vapes given that none were over the age of 21.

Therefore, there was a preponderance of the evidence that the SP failed to maintain professional boundaries and that the SP’s interactions with clients that were detrimental to their ongoing mental health and were a failure to supply necessary care, were a failure to protect from conditions or actions that seriously endangered their mental health, and were a failure to supply care or services which were reasonable and necessary.

It was determined that neglect occurred (a failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so. Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so. 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).

Regarding Sexual Abuse

Given the information provided by C1 and C8 that the SP “patted” them and other clients on the buttocks over their clothing and also made comments about “smacking” C1’s “butt,” that the SP was a staff person in authority

who intentionally touched their buttocks, which was an intimate part, and making comments that were in appropriate and sexual in nature, there was a preponderance of the evidence that the SP's conduct included statements and overt acts that represented a substantial risk of sexual abuse to C1 and C8.

It was determined that sexual abuse occurred (the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 - 609.3451 [criminal sexual contact in the first through fifth degree]).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

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

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

The SP was trained on the Reporting of Maltreatment of Minors Act and the facility's policies and procedures including the Program Abuse Prevention Plan and the Wings Code of Ethics and Practice. The SP was responsible for the maltreatment of the AV and C1-C11.

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 and sexual abuse for which the SP was responsible was recurring and serious maltreatment because the incidents occurred on multiple dates with multiple clients and included sexual abuse.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (c) all investigative data maintained in this report will be kept by the Department of Human Services for at least ten years after the date of the final entry in the report.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed by the SP. This included that the SP provided clients access to nicotine vapes and violated physical boundaries including using an open hand and patting various areas on their bodies over clothing, including on their buttocks. The SP also took photos and videos of the clients posing in "provocative" ways and made sexually inappropriate comments. There were no similar prior concerns. The SP no longer worked at the facility.

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

The SP was notified that s/he was responsible for recurring and 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.

Certification:

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right

to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.