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: 202509893

Date Issued: March 2, 2026

Name and Address of Facility Investigated:

Evident Social Services LLC
1558 E. 80th St.
Bloomington, MN 55425

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

License Number and Program Type:

1123501-Intensive Residential Treatment Services/Residential Crisis Stabilization

Investigator(s):

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Office of Inspector General
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Suspected Maltreatment Reported:

It was reported a staff person (SP) had sex with a vulnerable adult (VA).

Date of Incident(s): Between October 10 and 20, 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 November 4, 2025; from documentation at the facility and law enforcement records; and through three interviews conducted with two facility supervisors (P1-P2), and the VA's family member (FM). The VA was not interviewed by this investigator because during the investigation s/he was hospitalized due to mental health symptoms. The FM said the VA was discharged from the hospital but continued to experience on-going mental health symptoms. However, the VA agreed to participate in a forensic interview led by law enforcement and provided information to the facility which was included below. The SP was contacted during the investigation, however declined to be interviewed.

The facility was a two-story building, and the VA's bedroom was at the end of a hallway on the first floor. The VA's bedroom was on the opposite side of the facility as the facility staff office. The facility provided intensive residential treatment and crisis stabilization services to adults who were diagnosed with a serious mental illness. Length of stay in the crisis stabilization program ranged from one to ten days and in the intensive residential treatment program up to 90 days with reauthorization for individuals requiring longer lengths of stay.

Facility documentation showed the VA moved into the facility in early October 2025, after being hospitalized at a psychiatric unit. The VA had a history of "risky" behaviors that included impulsive decision making, exchanging sexual favors for drugs, and self-injurious threats. The VA had limited insight into personal safety, and social boundaries. The VA enjoyed doing his/her nails, taking showers, and doing his/her make-up. The VA was diagnosed with depression, anxiety, attention deficit hyperactivity disorder, and bipolar disorder. The VA was not subject to guardianship.

The VA's *Individual Abuse Prevention Plan* showed the VA was susceptible to sexual abuse.

The FM said s/he contacted P1 after the VA told the FM about a sexual relationship between the VA and the SP. The VA did not provide dates that sexual contact occurred to the FM, but the VA said there was social media messaging between the VA and the SP.

The facility completed a *Critical Incident* which showed the SP allegedly engaged in sexual contact with the VA on three different unknown dates. The facility had a video monitoring system at the facility, and the footage was under review to pinpoint dates/times that the SP and the VA were potentially alone with each other while at the facility. It was then discovered that there was a malfunction with the video recording system so there was no reviewable footage from October 14 to 20, 2025. There was no information the recording system had been tempered with by anyone, but rather a system error.

The facility completed an *Incident Report* which provided the following information:

- On October 20, 2025, the FM contacted P1. Prior to the conversation between P1 and the FM, the VA told the FM that the VA had sexual contact with the SP. P1 then spoke with the VA regarding this, and the VA was apprehensive to disclose information regarding the SP, but stated the interaction was consensual.

- The VA was unable to provide any dates or times in which the sexual contact occurred, but the VA said there was sexual contact on three separate occasions. During the first interaction the SP touched the VA's buttocks. During the second interaction the SP attempted to touch the VA's genitals. During the third interaction the VA and the SP had sex.

- The VA said s/he and the SP had messaged on social mediaand provided the messages to P1. P1 reviewed the messages which included, but were not limited to the following:

    - The social media messages started on October 16, 2025, at 9:31 p.m., and the last message was sent on October 19, 2025, at 10:37 p.m. The messages were sent to the VA from a social media account that included the SP's name and photograph.

    - The correspondence between the VA and the SP included statements of missing each other, and wanting to be together after the VA was discharged from the facility.

    - The SP asked if the VA wanted the SP to come in early to work at the facility, and offered to purchase multiple items for the VA.

    - The VA also stated concerns that s/he "smelled," and the SP sent an internet hyperlink for genital suppositories. The VA asked the SP what flavor s/he liked, and the SP provided a flavor s/he preferred.

    - The SP and the VA also messaged about "honey packs" and the SP said the honey packs made him/her "last a long time." The SP and VA discussed using the honey packs with each other. (An internet search showed "Honey Packs" were an over-the-counter supplement. Some brands of honey packets promoted enhanced sexual performance.)

- On October 18, 2025, information showed the SP was at the facility for one to two hours during non-work hours, and allegedly assisted the VA with fixing the VA's television.

LE records provided the following:

- LE noted the alleged sexual contact occurred between October 10 and 20, 2025. On October 18, 2025, P3 observed the SP at the facility outside of the SP's working hours, and it was stated the SP went into the facility to assist the VA with mounting a television.

- On October 20, 2025, the FM informed P1 of alleged sexual contact between the SP and the VA. P1 told LE that after learning of the alleged sexual contact s/he spoke with the SP over the phone regarding interactions the SP had with the VA. The SP said s/he had conversations with the VA on social media but denied s/he sent any communication that was sexual in nature. The SP also denied any physical contact occurred between him/her and the VA.

- On October 21, 2025, the VA engaged in escalated emotional behaviors, a county crisis team was contacted, and the VA was transported to the medical facility at 4 a.m. While in transport the VA stated, "I am acting out because I was raped by someone here."

- The FM told LE that s/he visited the VA in the hospital on October 24, 2025, and based on the VA's behavior believed the VA was in a "complete state of psychosis." The FM told LE that prior to the VA's hospitalization s/he spoke with the VA. During the conversation the VA told the FM the VA had sex with the SP in the VA's bedroom, but the VA was unable to remember the date of the incident.

- LE noted that initially the VA was unable to be interviewed during the LE's investigation as s/he was hospitalized due to mental health instability. However, the VA later completed a forensic interview at CornerHouse and provided consistent information in the forensic interview as to the other information in this report provided by the VA.

- LE made multiple attempts to interview the SP, however the SP retained an attorney and did not complete an interview.

- LE noted there was no known preexisting relationship between the SP and the VA before the VA moved into the facility.

- LE forwarded the information to Hennepin County Attorney's office for review and on November 20, 2025, the SP was charged with third degree criminal sexual conduct.

This investigator interviewed P1, P2, and the FM who all provided information consistent with LE records and facility documents.

P1, P2, and the SP were trained on client specific information, the facility's policy and procedures, client rights, professional boundaries, and the Reporting of Maltreatment of Vulnerable Adults.

Conclusion:

A. Maltreatment:

Between October 10 and 20, 2025, the VA and the SP allegedly engaged in sexual contact. The VA provided consistent information to the FM, P1, and in a forensic interview regarding sexual contact between him/herself and the SP. The sexual contact included the SP touching the VA's buttocks, attempting to touch the VA's genitals, and the VA and the SP having sex. The SP did not provide any information to LE or this investigator, however, while speaking with P1 the SP denied any physical contact occurred, and stated that conversation between the VA and the SP on social media was not sexual in nature.

Social media messages between the VA and the SP showed the VA and the SP engaged in multiple texts messages including some that were sexual in nature which diminished the SP's credibility. The messages included the SP offering to purchase multiple items for the VA, including a genital suppository with a preferred flavor, and messages about using "honey packs" with each other. Although the SP denied physical contact with the VA, given that the SP had reason to minimize his/her actions and had diminished credibility, and that the VA provided consistent information that sexual contact occurred, 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).

In addition, given the VA's history, it was reasonable that the VA would continue to need support to develop and maintain the necessary life and social skills to maintain his/her mental health symptoms. The SP's interactions with the VA would likely hinder 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. Given this and that the VA and the SP exchanged messages, several of sexual nature, there was a preponderance of evidence that there was a failure to maintain professional boundaries and that the SP's interactions with the VA were a failure to provide the VA with reasonable and necessary care.

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:
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> (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;
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> (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 received training on the VA's client specific programming, professional boundaries, and the Reporting of Maltreatment of Vulnerable Adults Act. Therefore, the SP was responsible for the 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 for which the SP was responsible was recurring maltreatment because there was more than one incident and serious maltreatment because it met the statutory definition.

It was determined that the substantiated neglect for which the SP was responsible was not recurring maltreatment because it was a single pattern of behavior and was not serious maltreatment because the VA did not require care of a physician.

The SP was disqualified from providing direct contact services.

<u>Action Taken by Facility</u>:

The facility completed an internal review and determined that the policies and procedures were adequate but not followed. The facility completed additional training with all staff persons regarding boundaries, Reporting of Maltreatment of Vulnerable Adults, and not entering a person's bedrooms without another staff person present. The event was not similar to past events. The SP no longer worked at the facility.

<u>Action Taken by Department of Human Services, Office of Inspector General</u>:

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.