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: 202210294

Date Issued: April 28, 2023

Name and Address of Facility Investigated:

Volunteers of America
105 Villa Drive
Mora, MN 55051

Volunteers of Minnesota
38 Union St N
Mora, MN 55051

Disposition: Substantiated as to financial exploitation of two vulnerable adults by a staff person.

License Number and Program Type:

1070715-H_CRS (Home and Community-Based Services-Community Residential Setting)
1070706-HCBS (Home and Community-Based Services)

Investigator(s):

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Licensing Division
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) used two vulnerable adults' (VA1 and VA2) funds for personal use.

Date of Incident(s): January 1 to December 31, 2022

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 9, paragraph (b), clause (1):

In the absence of legal authority a person willfully uses, withholds, or disposes of funds or property of a vulnerable adult.

Summary of Findings:

Pertinent information for this investigation was obtained remotely, including documentation from the facility; and through five interviews conducted with two supervisory staff persons (P1 and the SP), a facility staff person (P2), VA1, and VA2. VA1 and VA2 were not subject to guardianship.

VA1 was diagnosed with major depressive disorder and acute organic brain syndrome.

According to VA1's *Individual Abuse Prevention Plan*:

- Although VA1 was not under guardianship, s/he allowed the SP to assist him/her with some of his/her finances. VA1 did not understand how to manage his/her finances. Staff persons assisted VA1 with his/her finances, including writing checks, paying bills, and maintaining cash records. Staff persons maintained an "accurate ledger" of VA1's records.

- VA1 was not able to recognize mismanagement of funds. Staff persons were trained annually on recognizing signs of financial exploitation and reporting any suspected mismanagement.

VA2 was diagnosed with cognitive deficits. According to VA2's *Individual Abuse Prevention Plan*, VA2 was unable to handle financial matters. Staff persons intervened on VA2's behalf when VA2 was in a vulnerable situation. Staff persons were trained annually to recognize and report signs of abuse according to their training. The SP helped VA2 balance his/her checkbook and budget his/her upcoming financial needs.

VA1 had a safe in his/her bedroom where s/he stored cash. VA1 and VA2 each had a debit card that was kept inside a safe in the staff office. If VA1 or VA2 made a purchase, staff persons kept a receipt and documented the purchase on an electronic ledger once they returned to the facility. The ledger entry included the date, a description of the item(s), the staff person who assisted, and a verifier staff persons' initials.

Information from bank statements, receipts, online ledger, emails, and spreadsheets prepared by P2, from January 1 to December 31, 2022, showed the following examples (not in totality) of VA1's and VA2's finances:

- VA1's finances showed the following:

  - There were multiple purchases from Amazon and Paypal for items that were delivered to the SP's house address with digital receipts sent to the SP's facility email. There were no receipts put in VA1's financial documents for the purchases.

  - VA1's debit card was used multiple times at a restaurant near the SP's house to withdrawal large amounts of cash from an automated teller machine (ATM). There were no receipts in VA1's financial documents for the transactions.

  - There were multiple checks written out to "cash" that were endorsed on the back by the SP that were not documented on VA1's electronic ledger.

  - On September 7, 2022, there was an ATM withdrawal from VA1's bank account in the amount of $300 that was not documented on VA1's ledger. On September 9, 2022, there was an electronic receipt in the SP's facility email that showed a $300 payment to the SP's personal credit card.

  - On September 14, 2022, there was a debit card purchase from VA1's bank account to a cruise line in the amount of $203. There was no receipt and it was not documented on VA1's ledger.

  - The above transactions that were documented on the facility's electronic ledger had the SP's initials. The verifier's initials belonged to VA1, VA2, or the SP's spouse who also worked at the facility.

  - On October 13, 2022, there were multiple payments made with VA1's debit card to an airline company. The following day, October 14, 2022, the SP flew out of state to a treatment center. None of these transactions were documented on VA1's electronic ledger and there were no receipts in VA1's documents.

- VA2's finances showed the following:

  - There were multiple ATM withdrawals for large cash amounts that did not have a receipt or documented on VA2's ledger, including multiple times at a restaurant near the SP's house.

  - There were multiple checks written out to "cash" that were endorsed on the back by the SP. Some of these were documented in VA2's ledger, initialed by the SP and VA2 as the verifier and others were not documented on VA2's ledger.

  - There were multiple purchases from Amazon and PayPal for items with digital receipts sent to the SP's facility email. There were no receipts in VA2's financial documents.

  - On November 8 and 9, and December 8, 2022, there were three purchases for online gambling websites which were not entered on VA2's ledger and no receipts.

The facility determined there was a total of $3,433.85 and $6,900.68 of VA1's and VA2's respective funds that were questionable purchases or incorrectly documented including missing receipts. The SP went out of state to a treatment facility on October 14, 2022, and there were no additional questionable funds after October 27, 2022, except for three online gambling payments from VA2's account and two Amazon charges on VA1's account that were mailed to the address the SP was living out of state.

P1 provided the following information:

- The SP conducted monthly audits of the clients' finances and P1 conducted yearly audits. In December of 2022, P1 audited VA1's and VA2's finances for the year. P1 noticed some unusual charges on VA1's account, including a cruise line purchase and ATM withdrawals at a restaurant located near the SP's house. VA1's and VA2's initials were entered as the verifier, which should have been a staff person. There were recent Amazon purchases made from VA1's bank account that were delivered to where the SP was living out of state.

- P1 then went into the SP's facility email and saw emails that included payments to the SP's personal credit card for the same amounts as VA1's cash withdrawals.

- Every four months, VA1 received monthly payments that were approximately $2,000 to $5,000 each. VA1's online bank statement deposits were for "random amounts" and cash was also given back. P1 then went to review VA1's cash ledger and it was not inside VA1's safe. After finding it in a discreet location at

the facility, P1 saw that the ledger had not been completed for approximately one year prior so there was no record of VA1 receiving cash back from bank deposits. The SP and VA1 each had keys for VA1's safe where VA1's cash was stored. No one else had keys or access to VA1's safe.

- On one previous occasion many years prior, VA1 and VA2 went to the restaurant near the SP's house but not on a regular basis. VA2 did not have a cell phone and did not gamble but the SP enjoyed gambling at casinos.

- On a previous unknown date, prior to the SP going on a vacation, P1 asked the SP where s/he was going. The SP responded that s/he was taking a cruise and mentioned the same name as the cruise line that was listed on VA1's bank statement. The SP was on vacation from September 15 to 27, 2022. There were no unusual charges to VA1's and VA2's accounts during that time.

- The SP was supposed to return to work on approximately December 14, 2022, so P1 messaged the SP at the beginning of December about returning to work and the SP did not respond.

P2 provided the following information:

- On a previous occasion, P1 called P2 and asked about ATM withdrawals for clients. P2 told P1 that staff persons did not bring VA1 or VA2 to ATMs to withdrawal cash. If VA1 or VA2 needed cash, VA1 or VA2 wrote a check to themselves and brought it to the bank for cash and then documented it on the cash ledger.

- VA2's cash was kept in his/her financial book inside a pouch in the safe in the staff office and was documented on the electronic ledger. P2 stated that the SP, P2, and five other staff persons (P3-P7) had access to the safe.

- When VA1 took cash out of the safe in his/her bedroom, VA1 told P2. P2 then went into VA1's bedroom, counted the remaining cash, and documented it on the cash ledger. On one previous occasion, VA1 (who had memory issues) told P2 that there was supposed to have been $700 in his/her safe. P2 went and looked inside the safe, but there was no cash or ledger so P2 brought VA1 to the bank to take out additional cash. VA1 and the SP were the only persons with access to VA1's safe during that time.

- P2 stated that staff persons did not bring VA1 and VA2 to the restaurant near the SP's house within the year prior, but the SP told P2 "quiet a few times that [s/he] frequented" the restaurant. Staff persons were not allowed to keep clients' debit cards on them, especially when not working.

VA1 and VA2 were not aware their funds were missing until this investigation. VA2 stated if s/he needed cash, s/he went to the bank to withdraw cash and denied using ATMs. VA1 was not aware if staff persons were able to access his/her safe. VA1 denied taking a cruise in the prior year.

The SP provided the following information:

- VA1 worked at a day program and his/her checks were direct deposited into a bank account. VA1 also received monthly payments and at times put it in the bank or otherwise carried large amounts of cash with him/her or kept it inside the safe in his/her bedroom.

- VA1 was the only person who had a key to the safe. Staff persons used to have a key to the safe but approximately six years prior, VA1 broke his/her key so the SP gave VA1 the staff key. The SP was not aware if any other staff persons knew about the SP giving the key to VA1, except possibly P2. VA1's and VA2's debit cards were stored inside the safe in the staff office that all staff persons had access to.

- The SP "heard many times" that VA1 had missing cash from his/her safe. VA1 documented his/her finances and staff persons did not track VA1's cash. The SP stated on approximately October 13, 2022, the last time s/he was at the facility, VA1's cash ledger was inside his/her safe.

- Generally, VA2 gave staff persons a check to cash so VA2 had cash on him/her. Staff persons drove VA2 to stores and VA2 independently used his/her debit card when making purchases. VA2 "love[d]" to shop and purchased items s/he did not need.

- Staff persons then documented payments on the electronic ledger. Staff persons also kept receipts for purchases and placed the receipts inside each client's binder. The SP "generally kept an eye" on the clients' finances. The SP was not aware of any times in the previous year that VA1's and VA2's account balances were off or cash was missing.

- If VA1 or VA2 wrote out a check, ordered an item off Amazon, or took cash out of an ATM, then they could have been a verifier. VA1 and VA2 used ATMs at different places but "mostly" at the bank.

- When this investigator asked the SP about why VA1 and VA2 had missing cash, the SP responded that s/he had "no idea." When the SP drove VA1 and VA2 to the bank ATM, the SP stood in front of the ATM camera which looked "guilty."

- P1 was "very upset" that the SP took an extended leave and P1 had to cover the facility. Historically VA1 and VA2 both ate lunch at a restaurant near the SP's house, but the SP was not able to provide dates of when VA1 and VA2 were there. On one of those occasions, VA2 purchased pull tabs with cash taken out of an ATM. The SP denied using VA1's and VA2's funds.

- Previously, the SP brought VA1's and VA2's debit cards home with him/her by accident. The SP denied using VA1's and VA2's funds to purchase items off Amazon or pay for his/her medical bills.

- When this investigator asked the SP about a specific purchase made to a cruise line, the SP provided the following information:

    - The SP was not aware there was a purchase from VA1's bank account to the cruise line.
    - The SP then stated that on a previous occasion, when using his/her PayPal account to purchase cruise items, the SP saw VA1's bank account information in PayPal because the SP had previously used VA1's bank account to purchase items for VA1 through PayPal.
    - The cruise purchase went through before the SP realized it so the SP then gave VA1 cash as reimbursement for the purchase.
    - VA1 would not remember the SP paying him/her back because VA1 had memory issues. The SP did not tell any other staff person about the purchase.

- When this investigator asked the SP about Amazon purchases, the SP provided the following information:

    - The SP denied using VA1's and VA2's bank accounts for items that were mailed to the treatment facility where the SP stayed.
    - The SP then said at the time of the interview, s/he looked through his/her Amazon account and saw that on October 25, 2022, s/he "screwed up" and used the wrong debit card for a pair of shoes and hat in the amount of $62.49. The SP was unable to provide information as to whose debit card was used.
    - The SP also saw a purchase on October 15, 2022, in the amount of $27.54 for popcorn that was also paid by the other debit card.
    - The SP stated it "was possible" that when on the Amazon website, either VA1's or VA2's debit card numbers came up and s/he used that one instead of his/her own.

According to the facility's policy on financial management:

- The facility ensured that clients retained the use and availability of personal funds and property unless restrictions were documented.

- The facility ensured separation of clients' funds from other clients, the facility, or staff persons. When the facility assisted a client with safekeeping of funds or property, the facility had written authorization from the client, his/her guardian, and case manager. In addition, the facility:

    - Documented receipt and disbursement of funds or property;
    - Annually documented the preferences on the authorization form; and
    - Returned to the client upon request funds and property in the facility's possession subject to the client's annual plans as soon as possible or no later than three working days after the date of request.

- The facility and staff persons were not allowed to borrow money from a client; purchase personal items from a client; sell merchandise or services to a client; require a client to purchase items which the facility was eligible for; use client funds in a manner that would violate 256B.04 or any other rules under that section; or accept power of attorney for a client from the facility for any purpose or become a guardian.

- Supervisory staff persons provided training to staff persons on financial management procedures. Staff persons assisted clients with making bank deposits, writing checks, reconciling checkbooks and saving account ledgers, and managing personal funds. On a weekly basis, a designated staff person ensured the accuracy of each clients' financial documentation. Monthly a supervisory staff person ensured the accuracy of the financial entries and records.

Facility documentation showed that staff persons, including the SP, were trained on VA1's and VA2's plans, the facility's policy on financial management, and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

Law enforcement was contacted regarding the allegations and their investigation was ongoing at the completion of this report.

Conclusion:

A. Maltreatment:

Consistent information was provided that on previous dates, the SP took cash out of VA1's and VA2's bank accounts and safe. Copies for multiple checks for VA1 and VA2 that written out to "cash," were endorsed on the back by the SP, and were not documented in VA1's or VA2's electronic ledger. There were also multiple ATM withdrawals near the SP's house that were not documented on VA1's and VA2's cash ledgers.

Information was provided that on multiple previous dates, the SP used VA1's and VA2's funds to purchase items from PayPal and Amazon, including items delivered to the SP when staying in another state. The SP also made multiple purchases for things such as personal travel and online gambling and did not document the purchases in the ledger and did not provide receipts. Originally the SP denied using VA1's PayPal account to purchase items related to a cruise. Later, s/he said s/he reimbursed VA1 with cash since the charge went through before s/he realized it. The SP also said s/he "screwed up" and used the wrong debit card for Amazon purchases for him/herself.

The facility determined there was a total of $3,433.85 and $6,900.68 of VA1's and VA2's respective funds that were questionable purchases or incorrectly documented including missing receipts. The SP went out of state to a treatment facility on October 14, 2022, and there were no additional questionable transactions after October 27, 2022, except for three online gambling payments from VA2's account, for which VA2 did not gamble, and two Amazon charges on VA1's account that were mailed to the address the SP was living out of state.

Although the SP denied taking VA1's and VA2's funds, it was more likely than not that s/he did based on the following information:

- The SP and VA1/VA2 were the only persons who had access to VA1's and VA2's money.
- Consistent information was provided that VA1 stored his/her cash inside a safe in his/her bedroom. P1 and P2 provided information that the SP and VA1 were the only persons with keys to the safe. On a previous occasion, VA1 told P2 that s/he had cash in his/her safe but could not find it and VA1's cash ledger was missing for some time.
- The SP signed and endorsed the back of all the checks that were written out to "cash." The SP also initialed all the questionable transactions that were entered on the ledger and the SP's or the SP's spouse were the initials for the verifier.
- VA2 denied using ATMs for cash withdrawals and the SP stated for ATM withdrawals, s/he stood in front of the camera and looked "guilty."
- The SP was responsible for monthly audits of VA1's and VA2's finances and did not report any concerns accordingly during the one-year period.
- There was no information that VA1 and VA2 were aware of or authorized the purchases.
- The SP had reason to minimize his/her actions for fear of repercussions.

Therefore, there was a preponderance of the evidence that in the absence of legal authority, the SP willfully used VA1's and VA2's funds for personal purchases.

It was determined that financial exploitation occurred (In the absence of legal authority a person willfully uses, withholds, or disposes of funds or property of a vulnerable adult).

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 facility's policy on financial management, and VA1's and VA2's plans. 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 financial exploitation for which the SP was responsible was recurring maltreatment. The SP used or withheld funds from two vulnerable adults each on multiple occasions.

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 but not followed. On December 19, 2022, all staff persons received additional training on cash resources and staff responsibilities. The SP was placed on leave.

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.