

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: 202309313

Date Issued: March 6, 2024

Name and Address of Facility Investigated:

Our Homes South
505 14th Street Northeast
Owatonna, MN 55060

Our Homes South, Inc.
PO Box 119
113 North Main Street
Medford, MN 55049

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

License Number and Program Type:

1069038-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069034-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) took cash belonging to two vulnerable adults (VA1 and VA2) without the legal authority to do so.

Date of Incident(s): October 25, 2023

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 interviews conducted with VA1, VA1's guardian (G1) who was also VA1's family member, VA2, VA2's guardian (G2), community persons (CP1-CP3), facility staff persons (P1-P3), and a supervisory staff person (P4). More than one attempt was made by telephone, email, and mail to contact and interview the SP; however, the SP did not respond by the completion of this investigation.

VA1's support plan and support plan addendum provided the following information:

- In April 2023, VA1 moved into the facility seeking support and services relating to his/her diagnoses, which included moderate intellectual disability and autism spectrum disorder.
- VA1 was "funny and caring," and enjoyed staying busy.
- "[VA1] is vulnerable to maltreatment in all settings. [S/he] needs responsible supervision at all times. It is important to [VA1] to feel safe and to be safe."
- "[VA1] lacks money skills and is not able to manage [his/her] accounts independently. [S/he] would not be able to recognize mismanagement of [his/her] funds if using cash in the community. Staff offer skills training on how to manage finances ... When in the community [VA1's] cash transactions will be monitored and supervised by staff to ensure that [s/he] is not taken advantage of."

VA2's support plan and support plan addendum provided the following information:

- In September 2023, VA2 moved into the facility seeking support and services relating to his/her diagnoses, which included moderate intellectual disability and autism spectrum disorder.
- VA2 was "sweet, caring, funny, and always on the go." VA2 enjoyed attending car shows and sporting events, playing video games, and listening to country music.
- "[VA2] requires on-going supervision and a 24-hour plan of care of keep [him/her] safe."
- "[VA2] has a limited understanding of the value of money. [S/he] does not carry money on [his/her] person because [s/he] would not know how to manage it safely. [Staff] is in charge of the overall day to day management of [his/her] accounts and [his/her] petty cash account."

VA1 and VA2 lived together at the facility, which was a single-family home. The facility provided at least one staff person 24 hours a day for care and supervision.

The facility's petty cash policy stated the following:

- Each client had a petty cash pouch at the facility, which should not exceed \$25. Staff used a petty cash log to document the client's deposits and disbursement from their respective pouch.
- "There must be a paper trail for every penny of a client's cash." After an outing, there should be a receipt for purchases put into that client's petty cash pouch and the remaining money should be returned to the same pouch. Staff then logged this information on the petty cash log.
- The petty cash pouches were balanced and verified at each change of shift every day.

VA1 and VA2 each said that staff held onto their respective cash money including paying for items and keeping receipts. VA1 and VA2 each recalled attending a Halloween dance with the SP. VA1 said that the SP did not pay for them to attend the dance. VA1 did not know how they got into the dance without paying.

Facility documentation provided the following information:

- A staff schedule for October 25, 2023, included:
 - P1 worked between 7:30 a.m. and 4 p.m.;
 - The SP worked between 12:30 and 8 p.m.; and
 - P2 worked between 3 and 10 p.m.
- Progress notes included entries that VA1 and VA2 each attended a Halloween dance on October 25, 2023. The entries were initialed by the SP and timestamped as occurring during the SP's shift. [Note: Although the handwriting was difficult to determine, the initials for each entry appeared to match the SP's known handwriting of his/her initials on an unrelated training form.]
- VA1's and VA2's respective petty cash log each had an entry that on October 25, 2023, \$10 was withdrawn from their respective petty cash pouch for "Halloween Dance." There was no further documentation of the \$10 being deposited back into the pouch or any cash returned to the pouch in association to this. [Note: The petty cash logs did not state which staff person facilitated a withdrawal or a deposit. Rather, there were columns for staff to initial each day for the AM Staff Audit, PM Staff Audit, and Overnight Audit. The SP's initials were written for the PM Staff Audit on October 25, 2023.]

P1-P4 and CP1-CP3 provided the following information:

- P1 said that during the evening on October 25, 2023, the SP took VA1 and VA2 to the Halloween dance. The next day, P1 saw a handwritten receipt stating that VA1 and VA2 attended the Halloween dance for \$10 each. Staff were instructed to create a receipt for purchases when there was no official receipt from the vendor. The SP did this. P1 then completed the AM Staff Audit of the clients' petty cash pouches, and everything added up. VA1 and VA2 were each down \$10 compared to the day before but this was explained by the Halloween dance receipt.
- However, later that same day, P1 received an emailed invoice from the parks and recreation (parks and rec) department stating that VA1 and VA2 still owed money for the dance. The amount paid at the time of the dance was \$0.00 and the amount still due was \$20; \$10 for VA1's admittance and \$10 for VA2's.

- CP1-CP3 provided consistent information that participants of the Halloween dance needed to preregister and prepay to attend. The parks and rec department did not accept payment, including cash, at the door. VA1 and VA2 did not preregister and/or prepay. However, they were still allowed to attend the dance. Their names were added to a list and an invoice was sent to the facility for their attendance costs.
- P2 said that the SP brought VA1 and VA2 to the Halloween dance. P2 saw the SP take VA1's and VA2's \$10 cash to go to the dance. "They went to the dance. I don't know if they went anywhere else afterwards. I don't know if they spent the money after the party. Not sure. [The SP] took the petty cash."
- VA1's and VA2's respective petty cash logs and pouches did not document the return of the original \$10 cash or any other documentation to state that the dance was not paid for. There was also no documentation that the \$10 cash was used for another purchase.
- P4 said that when this concern was discovered, the SP called him/her about it. The SP told P4 that s/he did not take the clients' money. The SP said that s/he paid for VA1's and VA2's admittance to the dance. The SP did not provide additional information.
- P1 and the DHS investigator each contacted the parks and rec office (CP1-CP3), who confirmed that they did not accept payments at the door of the dance, including anything from the SP on October 25, 2023.
- P1-P4 each said that VA1 and VA2 did not understand the concept of money or have money management skills. When on community outings, staff were responsible for carrying and handling their money.
- P2 and P3 each said that the SP was having "interpersonal" or "financial issues" around the time of the incident.
- The facility reimbursed VA1 and VA2 for their respective, missing \$10 cash.

G1 and G2 each said that VA1 and VA2, respectively, did not handle and had limited understanding of their own finances. The facility was responsible for facilitating their individual purchases.

Facility documentation stated that the SP, P1, P2, P3, and P4 received training on the facility's petty cash policy, VA1's and VA2's respective support plans, and the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

A. Maltreatment:

Consistent information was provided that on October 25, 2023, VA1 and VA2 attended a Halloween dance with the SP. VA1's and VA2's petty cash logs stated that \$10 was withdrawn from their respective petty cash pouches to attend the dance. The \$10 was not deposited back into either pouch. The SP told P4 that s/he did not take the clients' money. The SP said that s/he paid for VA1's and VA2's admittance to the dance. However, the parks and rec department stated that they did not receive any payment from the SP for the dance. The facility received an invoice that VA1 and VA2 still owed \$10 each for the dance. There was no documentation of the clients' \$10

being used for another purpose or what happened to it. The facility later reimbursed VA1 and VA2 for their missing cash.

Given that VA1 and VA2 were unable to manage their own money, that P1 saw a handwritten receipt stating that VA1 and VA2 attended the Halloween dance for \$10 each, that the SP had control of VA1's and VA2's respective \$10 for the purpose of attending the Halloween dance, that information was consistent the \$10 was not used for either client's attendance at the dance, and that the \$10 was not returned to either client, there was a preponderance of the evidence that VA1's and VA2's money was used or withheld by a staff person who did not have the legal authority to do so.

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 received training on the facility's petty cash policy, VA1's and VA2's respective support plans, and the Reporting of Maltreatment of Vulnerable Adults Act. Although the SP denied taking VA1's and VA2's money and said that s/he paid for their admittance to the dance, CP1-CP3 each stated that the dance did not take cash and that VA1 and VA2 were admitted without paying. In addition, VA1's and VA2's respective petty cash log each had an entry that on October 25, 2023, \$10 was withdrawn from their respective petty cash pouch for "Halloween Dance." The SP was responsible for VA1's and VA2's care and supervision, and for taking VA1 and VA2 to the Halloween dance.

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 financial exploitation for which the SP was responsible was "recurring" maltreatment. The SP was responsible for using money that belonged to VA1 and VA2. The maltreatment finding did not meet the definition of "serious" maltreatment.

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. The facility reimbursed VA1 and VA2 for their missing money. The SP was no longer employed.

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.