

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: 202310885

Date Issued: March 28, 2025

Name and Address of Facility Investigated:

Dungarvin Minnesota LLC
1440 Northland Dr Ste 100
Mendota Heights, MN 55120

Disposition: Substantiated as to financial exploitation of four vulnerable adults by two staff persons.

License Number and Program Type:

1070806-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that four vulnerable adults (VA1, VA2, VA3, VA4) had unapproved transactions on their debit cards.

Date of Incident(s): January 31, 2024 and prior

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 was obtained during a site visit conducted on February 20, 2024; from documentation at the facility; and through four interviews conducted with one facility staff person (P), VA2, VA3, and VA4. VA1 was nonverbal and unable to provide any information. This investigator made attempts by phone and letter to reach two additional facility staff persons (SP1 and SP2), but attempts were unsuccessful.

VA1 was diagnosed with encephalopathy and enjoyed going out to eat.

VA2 was diagnosed with Parkinson's disease and enjoyed going for walks.

VA3 was diagnosed with cerebral palsy and enjoyed going on vacations.

VA4 was diagnosed with cerebral palsy and enjoyed celebrating holidays.

VA1's Annual Plan stated that VA1 had memory issues and could not manage his/her finances. Staff persons assisted VA1 in managing his/her finances and purchased personal needs items for VA1 as required.

VA2's Annual Plan stated that VA2 knew how s/he wanted his/her money spent and made his/her own decisions appropriately. The facility was VA2's representative payee and helped with income reporting and benefit renewals.

VA3's Annual Plan stated that the facility was VA3's representative payee but VA3 spent his/her money as s/he wished. VA3 asked for staff person assistance as needed.

VA4's Annual Plan stated that VA4 had limited knowledge of his/her finances and would not recognize if s/he was spending within his/her budget or was a victim of financial abuse. The facility was VA4's representative payee. Staff persons documented purchases made and were responsible for auditing VA4's account.

VA2 said that SP1 worked at the facility and sometimes shopped for VA2. VA2 remembered that SP1 had bought VA2 Skittles, gum, and pop.

VA3 said that SP2 used his/her debit card to purchase products at Ulta. VA3 did not wear makeup and had never been to Ulta. VA3 had in the past asked SP1 to purchase shampoo and conditioner for VA3 but not makeup.

VA4 said that sometimes s/he accompanied staff persons to do shopping but often s/he made a list for SP2 or another staff person that then made purchases for VA4. VA4 did not recall if there were items purchased with his/her debit card that s/he did not ask staff to purchase.

The P and the *Vulnerable Adult Internal Review Addendum* provided the following information:

- VA1, VA2, VA3, and VA4 each had debit cards that were issued by the facility. They acted like a credit card but had preventative measures placed on them including spending limits and they were not able to take cash out.
- On December 30, 2023, a staff person told the P that there were Christmas cards made out to staff persons on the desk. These cards were from VA4 and contained gift cards. It was against company policy

for clients to give staff persons gift cards. SP1 typically did activities with the individuals, and it was determined that SP1 had made the cards and purchased gift cards using VA4's money.

- SP2 was contacted to see if s/he knew about this, and s/he said that SP1 had VA4's debit card and SP2 was unable to get it from SP1. SP2 and another staff person were able to sign into VA4's Walmart account and see many purchases that VA4 would not have purchased including headlights for a vehicle and purchases for car washes. SP1 recently had issues getting to work because s/he had to replace the lights on his/her vehicle. There was also clothing/jewelry purchased for a gender that VA4 would not have purchased but were the same gender as SP1.
- The P attempted to contact SP1 to see where the debit card and receipts were but SP1 did not respond. VA1, VA2, and VA3's accounts were also checked because SP1 did a lot of activities with them as well.
- On January 1, 2024, SP1 came to the facility with some receipts but did not have an explanation for the spending. When asked if SP1 had other individual's cards s/he at first said that s/he did not, but then went to his/her vehicle and came back with VA2, VA3, VA4, and another individual's cards. VA1's debit card was not located.
- VA3 kept his/her card on his/her person and spent his/her money as s/he wished. The P was not sure how SP1 got VA3's card. VA3 spent time at a transitional care unit starting in September 2023, and returning to the facility in January 2024, so would not have made many of the purchases on his/her card.
- After a review of accounts, it was determined that between October 2023 and December 2023, SP1 made the following personal purchases: \$78.42 on VA1's debit card, \$78.42 on VA2's debit card, \$209.83 on VA3's debit card, and \$560.63 on VA4's debit card.
- It was also discovered while reviewing accounts that SP2 made a purchase with VA3's debit card to Ulta in the amount of \$907.75. The P would typically be notified if a large spend down for a client was completed but the P was unaware of this purchase.
- There were many items on the receipt that VA3 would be unable to use due to his/her disability. After looking at the facility and talking with VA3, it was determined that \$544.52 worth of items were not able to be accounted for. The receipt showed that SP2 received reward points on his/her Ulta card for the transaction. There were also some "suspicious" transactions on SP2's facility credit card.

This investigator attempted to contact SP1 for an interview, but SP1 did not respond to attempts.

SP2 did not respond to attempts for a formal interview. SP2 provided initial information that s/he was a supervisory staff person at the facility. SP1 assisted some of the individuals with their spending. When unaccounted transactions were noticed, SP1 had the individual's debit cards on his/her person. When reviewing purchases for the individuals there were many purchases that SP2 was not aware of and did not know anything about. There were purchases made in odd locations, at odd hours of the day, and near where SP1 lived which was not near the facility.

Financial statements showed the following unauthorized purchases:

- VA1's card showed two purchases to Target on December 13, 2023, for \$63.43 and \$5. Another purchase was made on December 28, 2023, to DoorDash for \$9.99.
- VA2's card showed two purchases at gas stations on November 11, 2023, for \$7.90 and \$2.82, a purchase at McDonalds on November 13, 2023, for \$5.45, and a purchase at a gas station for \$34.87 on December 14, 2023.
- On June 25, 2023, VA3's card showed a purchase at Ulta for \$907.75.
- The following additional purchases were on VA3's card during the period when s/he was at a transitional care unit: October 16, 2023 for \$15.25 and \$11.23 at a gas station, October 17, 2023, for \$14.46 at a gas station, October 18, 2023, for \$9.31 at a gas station, November 11, 2023, for \$3.24 at a gas station, November 13, 2023, for \$21.26 at Target and \$7.50 at another store, November 14, 2023, for \$11.32 at a gas station, November 16, 2023, \$11 at a car wash, \$8.68 at Dollar Tree, \$9.26 at Sally Beauty Supply, and \$24.21 at Home Depot, November 17, 2023, \$3.15 at a gas station, December 11, 2023, \$16.47 at Target, December 12, 2023, \$30.43 at Burger King and \$14.00 at a gas station, and December 16, 2023, \$17.00 at a car wash.
- VA4's card showed a purchase on December 13, 2023, at Macy's for \$102.93 (this included jewelry for a gender that VA4 would not wear), purchases on December 26, 2023, to Walgreen's for \$28.68 and to Walmart for \$55 (this included vehicle headlights), a purchase on December 27, 2023 at Target for \$440 (gift cards), and a purchase on December 28, 2023, at Walmart for \$59.12 (this included clothing that was not the same gender as VA4 wore).

The *Policy and Procedure Concerning Individual Finances and Funding Sources* stated that the facility used an electronic money management system to manage an individual's personal funds. All personal funds managed by the facility were held in a bank account with subaccounts set up for each individual. All receipts and/or invoices for all expenditures and/or payments were collected and maintained. Statements were reviewed by the program supervisor.

All staff persons were trained on the VA1, VA2, VA3, and VA4's plans, the facility's policies and procedures, and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

Conclusion:

A. Maltreatment:

Information was consistent that purchases were made on VA1's, VA2's, VA3's, and VA4's debit cards that were inconsistent with what they typically purchased. It was discovered that SP1 had VA2's, VA3's, and VA4's debit cards in his/her possession. SP1 provided some receipts for purchases but was not able to explain all the purchases. Purchases included clothing that was not appropriate for an individual, vehicle parts, car washes, and food purchased at locations that the individuals were not physically at the time and/or were not in close proximity to the facility. Additionally, when going through documentation it was found that SP2 had made a large purchase for VA3 at Ulta but VA3 did not receive all the products and many of the products purchased VA3 would not use or be physically able to use.

Given VA1, VA2, VA3, and VA4 had purchases made on their debit cards without their knowledge or consent and purchases included things they did not receive or use, there was a preponderance of the evidence that VA1's, VA2's, VA3's and VA4's funds were willfully used or withheld in the absence of legal authority.

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.

SP1 and SP2 were each trained on the VA1's, VA2's, VA3's, and VA4's plans, the facility's policies and procedures, and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

SP1 had in his/her possession VA2's, VA3's, and VA4's debit cards and could not reasonably explain the charges. SP1 was responsible for maltreatment of VA1, VA2, VA3, and VA4.

Additionally, SP2 made a large purchase at Ulta for VA3. VA3 did not receive all the products purchased and many of the products did not appear to be products that VA3 would/could use. SP2 was responsible for maltreatment of VA3.

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 SP1 was responsible was "recurring" as SP1 made multiple transactions on multiple dates on four different VAs' debit cards.

SP1 was disqualified from providing direct contact services.

It was determined that the substantiated financial exploitation for which SP2 was responsible did not meet statutory criteria to be determined as recurring or serious as it was a single purchase.

Action Taken by Facility:

The facility completed an internal review and determined that policies and procedures were adequate but not followed when SP1 and SP2 made personal purchases on individuals' debit cards. SP1 and SP2 no longer worked at the facility.

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

SP1 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 SP1 was responsible for maltreatment and the disqualification of SP1 are each subject to appeal.

SP2 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP2 was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of SP2. The determination that SP2 was responsible for maltreatment is subject to appeal.