

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: 202502385

Date Issued: July 17, 2025

Name and Address of Facility Investigated:

Pinnacle Dean
310 Dean Ave. E
Champlin, MN 55316

Pinnacle Services Inc
724 Central Ave NE
Minneapolis, MN 55414

Disposition: Substantiated as to financial exploitation of two vulnerable adults (VA1-VA2) by a staff person.

License Number and Program Type:

1113352-H_CRS (Home and Community-Based Services-Community Residential Setting)
1069733-HCBS (Home and Community-Based Services)

Investigator(s):

Jason Pehler
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
Jason.Pehler@state.mn.us
651-431-4830

Suspected Maltreatment Reported:

It was reported a staff person (SP) used two vulnerable adults' (VA1-VA2) bank accounts to make unauthorized automatic teller machine (ATM) transactions.

Date of Incident(s): Multiple incidents from May 2023 to July 2024.

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:

DHS completed a previous investigation regarding similar allegations involving the SP. The report (#202407000) was substantiated for financial exploitation. Within that investigation it was discovered that from August 16, 2023, through August 1, 2024, there was \$4,000 in ATM withdrawals from a vulnerable adult's bank account. The cash withdrawals were not documented in that vulnerable adults *Petty Cash Tracker* and the VA's petty cash balance did not change to reflect the cash withdrawals. LE obtained ATM security videos from multiple suspicious ATM withdrawals which showed the SP, and/or the SP's vehicle, were present when the withdrawals were made. The SP employee responsibilities included reviewing the vulnerable adult's bank statements and petty cash on a regular basis but there was no information that the SP identified or reported any concerns regarding the finances during this time. LE and this investigator attempted to contact the SP, but the SP did not respond to interview requests. The SP was charged with criminal financial transaction card fraud for use of the VA's debit card without consent. Due to the financial exploitation the facility completed a review of other vulnerable adults' finances due to the previous report. The SP was not employed by the facility when the financial exploitation in this report was alleged.

Pertinent information for this investigation was obtained remotely, including documentation from the facility; and through two interviews conducted with a facility supervisor (P1) and VA2's guardian (G). The G but did not have pertinent information related to the investigation. VA1 was not subjected to guardianship. VA1's and VA2's case manager (CM) was aware of the investigation but did not have additional information. Based on the information obtained VA1-VA2 had no pertinent information related to the allegation, and would be exposed to undue emotional stress if interviewed. This investigator attempted to contact the SP by mail, however, the SP did not respond. Additionally, Law Enforcement (LE) attempted to interview the SP, however, LE was unable to locate the SP.

Facility documentation showed VA1 enjoyed being at home, and was described as sweet, kind, and smiley person. VA1 loved wearing soft robes and enjoyed books, toys, puzzles, and watching Disney shows and cartoons. VA1 was diagnosed with development disabilities, depression, and Raynaud's disease.

Facility documentation showed VA2 was outgoing, friendly, and loved spending time with family and friends. VA2 enjoyed watching television, going shopping, and completing community activities. VA2 was diagnosed with developmental disabilities, seizure disorder, and cerebral palsy.

VA1's and VA2's *Individual Abuse Prevention Plan(s)* stated:

- VA1 and VA2 were each unable to handle their finances and needed the assistance of their support team and staff persons. VA1 and VA2 did not understand financial exploitation.
- VA1 and VA2 required staff persons assistance in the community to manage their finances and staff persons would be responsible for any cash, debit/credit cards, or checks.
- Staff persons would safely store VA1's and VA2's cash, debit/credit cards, and checks, obtain receipts, and document all transactions. A supervisor (SP) would monitor VA1's and VA2's bank accounts as needed.
- Staff persons would intervene if there was suspected or observed financial exploitation.

VA1's and VA2's *Funds and Property Authorization* provided the following:

- The facility was authorized to assist VA1 and VA2 with safekeeping of their funds and property.
- The company and program staff persons were to not borrow money from a person served by the program.
- VA1 retained the use and availability of personal funds or property unless restrictions were justified and documented in individual plans.
- Staff persons were to immediately document receipt and disbursement of VA1's funds or other property at the time of receipt or disbursement, including the person's signature, or the signature of the conservator or payee.
- VA1's and VA2's debit cards were securely stored, along with their Personal Identification Numbers (PIN). Staff persons would assist VA1 and VA2 with using their debit card, and managing online banking as needed. A supervisor would conduct monthly audits of the bank account expenditures, and compare them with receipts. Any discrepancies would be reported to the facility administration and the G (for VA2).

The facility reviewed VA1's bank statements and identified ATM withdrawals totaling \$3,800 that were suspicious:

- June 26, 2023: \$300
- July 24, 2023: \$300
- August 7, 2023: \$200
- August 15, 2023: \$200
- October 3, 2023: \$300
- October 13, 2023: \$300
- October 26, 2023: \$300
- January 24, 2024: \$300
- February 2, 2024: \$200
- April 8, 2024: \$300
- June 10, 2024: \$300
- June 17, 2024: \$300
- July 5, 2024: \$200
- July 11, 2024: \$200
- July 31, 2024: \$100

VA1's petty cash tracking sheet at the facility showed no documentation of the money withdrawn from the bank account.

The facility reviewed VA2's bank statements and identified ATM withdrawals totaling \$5,300 that were suspicious:

- May 1, 2023: \$200
- May 30, 2023: \$200
- June 13, 2023: \$100
- June 16, 2023: \$200
- June 26, 2023: \$200
- July 24, 2023: \$300
- July 26, 2023: \$300
- August 7, 2023: \$200
- August 15, 2023: \$300
- October 3, 2023: \$200
- October 13, 2023: \$200
- October 26, 2023: \$200
- December 18, 2023: \$200
- January 24, 2024: \$300
- February 2, 2024: \$200
- April 8, 2024: \$400
- June 10, 2024: \$300
- June 17, 2024: \$300
- June 24, 2024: \$400
- July 5, 2024: \$100
- July 11, 2024: \$300
- July 31, 2024: \$200

VA2's petty cash tracking sheet at the facility showed no documentation of the money withdrawn from the bank account.

During this investigation LE was unable to obtain any video recordings from the above withdrawals. LE attempted to contact the SP, but the SP did not respond, and LE made their investigation inactive as of May 14, 2025.

P1 provided the following information:

- VA1's and VA2's debit cards and petty cash were stored in a locked cabinet within the locked staff office at the facility. All staff persons at the facility, including the SP, had access to the VA's debit card and petty cash.
- The SP was responsible for ensuring the safety of the VA's finances by reviewing VA1's and VA2's bank statements, and petty cash records and balance.
- P1 said no other staff persons was identified during the facility's investigation to be involved in the unauthorized transactions.

The facility completed *Internal Reviews (IR)s* for the money missing from involving VA1 and VA2. The IRs provided the following information:

- A staff person informed the facility that the SP frequently claimed s/he forgot to return VA1's and VA2's debit cards, however it was common practice for the SP to assist VA1 and VA2 with purchases, and therefore it was not considered suspicious at the time. This occurred during the timeframe in which the alleged financial exploitation occurred.
- The SP had set up online banking for VA1 and VA2. VA2's paper bank statements had allegedly been placed on "hold" by the G. However, the facility suspected the SP had placed the statements on hold as the G informed the facility s/he was not even aware of the bank VA2 used. The G also told the facility the SP had contacted him/her about the SP taking over guardianship of VA2 in the future. The SP had also placed VA1's paper bank statements on hold.

The facility's *Policy and Procedure for Safeguarding Funds of Individual Served* included the following:

- Staff persons were not allowed to borrow money from an individual served by the program.
- Staff persons would immediately document receipt and disbursement of the funds of individuals served.
- Staff persons would obtain an itemized receipt for each transaction of cash and/or automatic teller machine (ATM), and an on-going balance of cash resources would be maintained on a form each month.
- On a weekly basis, an administrative staff person was responsible for counting all cash on hand, reviewing receipts, and comparing the monthly expenditure form for cash to ensure accuracy. The administrative staff person would follow up with staff immediately with all inaccuracies.
- On a monthly basis, the administrative staff person was responsible for balancing the cash, and documenting the amount carrying over to the next month.
- Any known or suspected maltreatment of a vulnerable adult, including misappropriation of funds, would be reported to the facility's "Chain of Command" immediately, a Minnesota Adult Abuse Reporting Center (MAARC) report would be filed, and an investigation would be initiated.

P1 and the SP completed training on the VAs' client specific information, the facility's policies and procedures, and the Reporting of Maltreatment of Vulnerable Adults Act. In addition, the SP completed trainings on client finances, petty cash, handling vulnerable adults' funds, and the prohibition of borrowing or lending items between staff persons and vulnerable adults.

Conclusion:

A. Maltreatment:

It was reported the SP used the VA1's and VA2's bank account to make unauthorized transactions. From June 2023, through July 2024, there was a total of \$9,100 withdrawn from VA1's and VA2's bank accounts. LE and this investigator attempted to contact the SP, but the SP did not respond to interview requests. During the previous maltreatment investigation, the SP was criminally charged for his/her actions which were described in DHS report #202407000. Although all staff persons had access to VA1's and VA2's debit card, there was no information any

other staff made the unauthorized transactions, nor did those staff persons have the responsibility to review VA1's or VA2's bank statements. It was more likely than not that the SP made the ATM withdrawals with VA1's and VA2's debit cards and did not use the money for VA1 or VA2.

The unauthorized withdrawals occurred during a similar timeframe, the cash withdrawals were completed at ATM's sometimes multiple times per month multiple hundreds of dollars, the withdrawals were not documented in VA1's or VA2's *Petty Cash Tracker*, and their petty cash balances did not change to reflect the cash withdrawals. Additionally, there were times the SP did not return VA1's and VA2's debit cards to the facility, and therefore had access to those debit cards for unknown periods of time. Furthermore, the SP's employee responsibilities included reviewing VA1's and VA2's bank statements and petty cash on a regular basis, but there was no information that the SP identified or reported any concerns regarding the finances during the time frame of the alleged financial exploitation. Therefore, there was a preponderance of the evidence that in the absence of legal authority the SP withheld, used, and or disposed of VA1's and VA2's funds.

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 Reporting of Maltreatment of Vulnerable Adults Act, the facility's policies and procedures, and VA1's and VA2's client specific information. 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 because there was more than one occurrence of financial exploitation of VA1 and VA2.

Action Taken by Facility:

The facility completed an internal review and determined that the policies and procedures were adequate, but not followed. The facility completed staff training, specifically related to safeguarding persons served funds. 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 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.