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: 202407900

Date Issued: July 30, 2025

Name and Address of Facility Investigated:

REM Hennepin, Inc. - Crosstown I
6125 Nicollet Avenue South
Minneapolis, MN 55419

REM Hennepin, Inc.
6600 France Avenue S Ste. 350
Edina, MN 55345

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

License Number and Program Type:

1071739-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071738-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that a staff person (SP) intercepted and cashed a vulnerable adult's (VA) disability checks from 2021 to 2023.

Date of Incident(s): Multiple dates prior to August 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 a life insurance company (LIC); and through seven interviews conducted with the VA, one supervisory facility staff person (P1), two administrative facility staff persons (P2 and P3), a community person (CP) who worked at the LIC, the SP's significant other (SO), and the SP. The SO and the SP each ended their interviews prior to the completion. The VA was interviewed for this investigation, but did not have information pertinent to the investigation other than that his/her work paychecks were paid to him/her via direct deposit.

According to the VA's plans, the VA was diagnosed with a mild intellectual disorder, seizure disorder, autism, and atypical psychosis. The VA enjoyed watching TV, spending time with family, finding CDs at the local music store, and drawing pictures. The VA's *Risk Assessment* plan stated that the VA did not consistently understand how to manage his/her finances and was trusting of others. The VA was unable to recognize mismanagement of his/her finances. The VA kept a small amount of cash on his/her person to use at his/her discretion. Facility staff persons were to "remain vigilant" to signs that financial exploitation might be occurring. The VA was not subject to guardianship and the facility was the representative payee. Those duties were handled by the SP at the facility's administrative offices. Facility documentation stated that the SP's position was not responsible for managing the VA's funds, but would work with Social Security funds, or assist with processing of payments.

Recorded phone calls and other documentation from the LIC provided the following information:

- On August 27, 2019, the LIC received a letter from a representative payee company, assigned to care for the VA's money. The company had been assigned as the representative payee when the VA lived at a previous facility. The letter said that the VA moved, and that the current representative facility was resigning, therefore, the VA was going to have a new representative payee. The new representative payee would be the facility (or someone working in the facility administrative offices). The letter asked the LIC to stop transferring electronic funds to the VA's bank account and begin issuing paper checks to the VA. The VA had been receiving checks for Social Security Disability (SSD) payments from the LIC in the amount of $179.80 monthly.

- On September 4, 2019, a claims manager from the LIC created a note in the VA's file that s/he called the letter sender to ask several follow up questions. The former representative payee had been designated by Social Security and had forwarded all checks to the facility's admirative office. The LIC had not yet been notified of the VA's move from the old facility to the new facility. The letter sender told the claims manager at the LIC that they could send the checks directly to the VA.

- On September 6, 2019, the claims manager created a note in the file stating that the facility applied to be the VA's new representative payee, but was waiting for Social Security's approval, and that they were currently withholding the VA's monthly benefit until they had the proper guardianship paperwork. Later that day, the claims manager created another note that s/he spoke to the SP to find out if the facility was appointed as the representative payee for the VA. The SP told the claims manager that the facility had not yet been appointed and that the process was taking "longer than expected." The claims manager asked the SP where the VA lived. The SP told the claims manager that the VA lived in one of the facility's

residential houses, but that they could send the checks to the facility office, where the SP worked and that they "would put it in [the VA's] account for [his/her] needs."

- On September 16, 2019, the claims manager sent a letter to the SP stating that currently, the VA's monthly SSD benefits were on hold, but that the LIC would begin making payments to the new representative payee once they received "satisfactory" evidence that the facility was supposed be receiving those checks on behalf of the VA.

- On September 26, 2019, the Social Security Administration (SSA) sent a letter to the VA at his/her physical address stating that the facility was the VA's new representative payee, stating, in part, "We have information that shows you still need help managing your money and meeting your needs."

- On October 15, 2019, the claims manager at the LIC mailed a letter to the SP stating that they received the SSA letter appointing the facility as the new representative payee, however the LIC still needed sufficient evidence that the facility was legally authorized to manage the VA's SSD benefits.

- On October 25, 2019, the SP called the claims manager and asked him/her what information was sufficient to provide them as the VA was not subject to guardianship. The SP told the claims manager that in some cases, the representative payee was the guardian but not always. Since the VA did not have a guardian, the SSA approved the facility as the representative payee and the SP did not know why that was not sufficient evidence for the LIC. The claims manager said that s/he would discuss with his/her supervisor.

- On October 31, 2019, the LIC sent a letter to the VA asking him/her to sign and return a form to the LIC if s/he agreed that the facility could manage his/her SSD benefit checks. The VA signed the form authorizing this on November 6, 2019.

- On November 7, 2019, the LIC received the signed authorization form from the VA and sent a letter to the SP. The letter stated that they had received authorization, and that the VA would be receiving a check in the amount of $359.97, which was for the withheld payments from September and October 2019, plus interest. The letter went on to say that after that, the VA would receive monthly benefits in the amount of $179.80 until the VA's "retirement date." (Investigator's note: the checks were to end when the VA turned a certain age and "aged out" of the policy which occurred in August of 2023 and the VA received his/her last check in August 2023.)

- Checks from November 2019 through September 2020 were deposited into the VA's account and the check endorsement appeared to be valid.

- There was a gap in checks being sent monthly, with a payment of $1,2610.49 to cover seven months (October 2020 through April 2021) being issued by the LIC on March 30, 2021. This check was not deposited into the VA's account and the endorsement on the back was not the VA's name and stated "Pay to the order of" the first name of one of the SP's family members and an illegible last name. According to the LIC, this appeared to be the first check that was not deposited to the VA's account.

- On June 26, 2024, the SO called the LIC and spoke with a representative. The SO told the representative

that s/he had found a check in the name of the VA at the SP's home. The VA was a client at the facility where the SP worked the SO referenced check number 1400253. The check was issued on June 26, 2023, and the amount was $179.80.

- The following were not deposited into the VA's account. These checks were for $179.80 unless specified. The U.S. Bank account was not the VA's.
  - May 1, 2021 – missing or canceled by the LIC after not being cashed.
  - September 1, 2021 – deposited in unknown account on August 22, 2022.
  - November 1, 2021
  - December 1, 2021
  - February 1, 2022 – deposited into a U.S. Bank account endorsed with the VA's name and then pay to the order of, first and last names of the SP's family member.
  - March 1, 2022 - deposited into a U.S. Bank account endorsed with the VA's name and then pay to the order of, first and last names of the SP's family member which was the SP's former last name.
  - April 1, 2022
  - May 1, 2022 - deposited into a U.S. Bank account with an illegible endorsement of the VA's name and then pay to the order of and illegible name.
  - June 1, 2022 - deposited into a U.S. Bank account with the endorsement with the VA's name and then pay to the order of, first name of the SP and the last name illegible.
  - July 1, 2022 - missing or canceled by the LIC after not being cashed.
  - August 1, 2022 - missing or canceled by the LIC after not being cashed.
  - September 1, 2022 - deposited into a U.S. Bank account endorsed with the VA's name and then pay to the order of, first name of the SP and the last name illegible.
  - October 1, 2022 - deposited into a U.S. Bank account.
  - November 1, 2022 - missing or canceled by the LIC after not being cashed.
  - March 30, 2023 - deposited into a U.S. Bank account.
  - April 26, 2023 - deposited into a U.S. Bank account.
  - June 26, 2023 - deposited into a U.S. Bank account. The SO called the LIC after finding this check.
  - August 28, 2023 - deposited into a U.S. Bank account.

- The third-party financial institution was notified by the LIC and stopped payment on uncashed checks after the LIC got a phone call from the SO on June 26, 2024. The third party put a stop-payment on the following checks on July 3, 2024. Those checks were paid in the amount of $179.80 and the issue dates were listed below:
  - December unknown, 2022
  - January 6, 2023
  - February 1, 2023
  - March 3, 2023
  - May 31, 2023
  - July 23, 2023

Law enforcement records and information obtained from U.S. Bank by law enforcement showed that the U.S.

Bank account that the VA's checks were being deposited into was the SP's family member's account.

The SP provided the following information:

- When the SP worked for the facility, s/he initially worked in the office at the facility headquarters until the Covid-19 pandemic required that staff persons did portions of their work from their homes. The SP was a representative payee and said that s/he "made sure [clients] were getting their benefits," and handled billing responsibilities. During the Covid-19 pandemic, with the SP temporarily assigned to do most duties at home, the facility gave the SP and other staff persons "legitimate private" laptops to use. Staff persons did not use any personal computers while working at home.

- Checks that were received on behalf of clients were deposited at the office "no matter what" and the SP denied that s/he would have any client checks or stubs at his/her house. The SP also denied that any client checks were mailed to the SP's house. The SP denied depositing any client checks into his/her own account or into the account of a family member or spouse and stated that s/he was "getting freaked out" by the line of questioning by this investigator. The SP denied ever taking any client checks to his/her house and was "confused" why s/he would be "accused" of doing so since s/he said all check deposits were done at the facility office. The SP said s/he did not have that type of "stuff" at his/her home, and did not want to be "set up" for something, get "discombobulated," or "say the wrong things."

- The SP did not know why someone would say that s/he had client checks at his/her home and did not know if s/he should continue to talk. The SP was "confused."

- The SP described the process for depositing checks at the office; there was a check scanner program at the facility office where checks were scanned into the "system" electronically. Staff persons, including the SP would go to the office for one to two hours, one to two days a week to use the scanning software. This meant that staff persons, including the SP did not have to go to a bank to do deposits and that client checks did not leave the facility office.

- The SP stated that s/he "wouldn't" have a client's check or copies of a client's check stubs at his/her house, even during the working from home period. The SP denied ever having any client checks at his/her house that were for the facility or the clients, even if the SP was listed as the representative payee. The SP said that all the checks were for the facility and were deposited into the facility account electronically.

- The SP said that all checks that were made out to a specific client's name would be mailed to the facility where each VA lived and then those checks would be cashed by the person at the physical facility location where the client was living.

- The SP stated that mail would be opened by other staff persons at his/her office when it was received by the front desk. The SP named P2 as one of the front desk staff persons but could not recall names of other staff persons assigned to the front desk due to the SP working from home, the facility switching buildings, and there being "a lot" of people working in that role.

The SO provided the following information:

- The SO initially stated that s/he "did not know" if s/he had anything to say about anyone cashing the VA's checks received by the facility. Upon being asked if s/he made a phone call to the LIC, which was located outside the State of Minnesota, the SO said that s/he "did not know" if the SP actually cashed any checks that were found at the SP's home.

- The SO said that when the SP worked at the facility, that the SO saw checks at the SP's home desk that were not addressed to the SP.

- When asked what the SO knew further about the allegations, the SO stated, "I'm not saying that I know anything, but if I did know something, and I didn't say something, and I was accused of knowing something, they would have to prove that I know something. Which I don't know anything." The SO also stated that talking to this investigator would be a "moral complexity" and that the SO "did not want to derail" the SP, even though there were "other people to consider" in this situation.

- The SO ended the call and stated that s/he would be available to speak with this investigator in several hours at a specific time, but did not answer or return phone calls or voice messages left by this investigator.

P2 and P3 provided the following information:

- P2 and P3 also worked at the facility offices and worked with the SP. P2 stated that part of his/her job duties were to get the mail and to separate it based on where it needed to go. P3 helped P2 with sorting mail when P2 was gone. P2 and P3 logged checks that came in and put them in a secured lock box which was also stored in a secure room. The SP was on the accounts receivable team and was one of several staff persons who had access to the secure room. Although the SP no longer worked for the facility, when s/he did, the SP and one other staff person were responsible for scanning in the checks to do electronic deposits. P2 did not have additional information regarding the check cashing process.

- P3 explained that there was a check scanner in the facility office that was used to scan the checks, which endorsed them with a digital "stamp" that would list the deposit information. The typical checks that they deposited were made out to the facility name and not the name of the client, but there were exceptions. If an envelope was opened by P2 or P3 but it was for a client at one of the facility houses, it was not logged or stored in the secure box. Those envelopes were placed into the office mail slots or were sent to the physical address where a client lived.

- P2 stated that the VA's checks would have gone to the SP, or the other staff person assigned in accounts receivable.

- According to P2, there was no reason why client checks or check stubs would end up at any staff persons' homes. P3 stated that most of the checks did not have a "stub" because they were deposited remotely using the software in the office, and P3 could not think of any circumstances where a staff person would take a check or stub home, especially since there was no way to deposit the check into a client's account outside of the facility office.

P1 provided the following information:

- The CP from the LIC called P1 to notify him/her of "potential fraud" on the VA's account after receiving information from the SO about the VA's check. The CP indicated that endorsement signatures on the backside of some of the checks from the last few years looked different than multiple examples of the VA's signature that were on file on other documents at the LIC.

- The CP was unable to release many details to P1, and therefore P1 did not have many details, but summarized that it appeared as though the SP had been "intercepting" some the VA's checks at some point between 2019 and 2023 with only some of the issued checks being deposited into the VA's bank account.

- At the time of the interview with P1, the VA did not know that this had occurred or that finances were "missing" and "probably would not be able to provide information." The VA had "other funds" that allowed him/her to meet his/her other needs.

- The SP worked at the facility until December 2023.

Facility documentation showed that after an interview with a supervisory staff person at the VA's residence, that when the VA moved into the facility, s/he was getting checks from the LIC but that s/he was not sure why the VA was receiving these checks. At the time, the supervisory staff person would pick them up at the facility's administrative office when they were placed into the mailbox that was on site for that address' and client mail. The supervisory staff person did not know why the VA stopped getting the checks, but at one point, the VA had received them monthly.

All facility staff persons interviewed for this investigation were trained in the Reporting of Maltreatment of Vulnerable Adults Act.

<u>Conclusion</u>:

A. Maltreatment:

Information from the facility, the CP, and the LIC showed that the VA was receiving checks in the amount of $179.80 until s/he reached a certain age in August 2023.

According to P1, P2, P3, and the SP, the SP was responsible for representative-payee payments on behalf of some clients at the facility. The SP acted on behalf of the facility as a representative-payee for the VA. The specific duties of cashing checks on behalf of the VA were to be done in the office, electronically with equipment that used an electronic signature. P1, P2, P3, and the SP stated that there would be no reason why the VA's checks or check stubs would be brought to the SP's home.

Information from the CP, the LIC, and the facility, showed that once the SP began representative-payee duties for the VA in November 2021, not all checks sent to the VA at the facility office were deposited into the VA's account. This continued until the SO called the LIC on June 26, 2023, to inquire about a check of the VA's that s/he found at the SP's home. The SO was calling the LIC to ask if the check had been cashed because it was in the name of the VA who lived where the SP worked. The CP and the LIC began looking into other checks that had been sent to the VA.

Information from the CP, the LIC, and the facility, showed that some of the VA's checks were endorsed by the VA and deposited into his/her account. However, some the VA's checks had been endorsed by the VA but then also said pay to the order of the SP's family member's name or the SP's name and that the checks were being deposited into accounts other than the VA's, including the SP's family member's US Bank account.

The SP stated that checks that were received on behalf of clients were deposited at the office "no matter what" and denied that s/he would have any client checks or stubs at his/her house. The SP denied that any client checks were mailed to the SP's house. The SP denied depositing any client checks into his/her own account or into the account of a family member or spouse.

Given that it was the SP's responsibility to deposit the VA's checks, that the SO found one of the VA's checks at the SP's home which was deposited into a bank account that was not the VA's, that the SP stated that s/he had no reason to have any client's checks at his/her home, that some checks were deposited into accounts that were not the VA's and had endorsements that matched the name of the SP and the SP's family member, and that the SP had reason to minimize his/her actions for fear of consequences, there was a preponderance of the evidence that the SP willfully used, withheld, or disposed of the VA's funds 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.

The Department of Human Services had information that on March 12, 2021, the SP had a name change but the facility did not submit a background study for the SP as required. On May 9, 2023, the SP was disqualified for

reasons unassociated with this report and after the appeal process it was determined that the disqualification was not set aside and on July 21, 2023, the SP remained disqualified. The facility did not receive the notification to remove the SP because the disqualification was associated with the SP's current name, not the name associated with the facility, so the SP continued to work at the facility. However, given that the financial exploitation occurred several times prior to this so removing the SP at the time of the disqualification would not have prevented it, the facility's responsibility was mitigated.

The SP was trained on the Reporting of Maltreatment of Vulnerable Adults Act. 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 because there was more than one occurrence of financial exploitation.

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

The facility's *Internal Review* showed that the VA's plans, policies, and procedures were adequate, but not

followed. The incident was not similar to a past event with the VA, but the SP had a prior record of discussion on file at the facility for "accidental" use of a different client's credit card for the SP's personal purchases. The SP no longer worked at the facility. The facility reimbursed the VA $7,012.20.

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 for the maltreatment in this report. The determination that the SP was responsible for maltreatment is subject to appeal.

On July 30, 2025, the license holder was ordered to forfeit a fine of $200 fine for the background study violation. The Order to Forfeit a Fine is subject to appeal.