

**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:** 202510385

**Date Issued:** January 27, 2026

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive

Vanessa Carey Adult Foster Care  
Sunshine Family Care  
5272 Falcon Drive  
Hermantown, MN 55811

**License Number and Program Type:**

1109376-AFC (Adult Foster Care)  
1109634-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that the facility financially exploited a vulnerable adult (VA) when they received payment for staffing from the VA's county waiver and also requested and received payment for the same staffing from the VA's special needs trust fund. In addition, it was reported that the facility used the VA's trust fund to purchase a wheelchair accessible vehicle that was also used by other clients.

**Date of Incident(s):** Ongoing between January 2022 and June 2025

**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 (a), clause (2), paragraph (b), clauses (1-3):**

In the breach of fiduciary obligation recognized elsewhere in law, including pertinent regulations and contractual obligations . . . a person fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult

In the absence of legal authority a person:

- willfully uses, withholds, or disposes of funds or property of a vulnerable adult.
- obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult; and
- acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud.

**Summary of Findings:**

Pertinent information was obtained during a site visit conducted on November 18, 2025; from documentation at the facility; and through six interviews conducted with the VA's guardian (G), the VA's case manager (CM1), the VA's trust manager (TM), the VA's trust case manager (TCM), and facility supervisory staff persons (the SP and the P). At the site visit, this investigator met the VA, who was lying in bed and did not respond when introduced. The VA was attached to a ventilator to help him/her breath and was not able to sit up or turn his/her head with ease. The VA was not interviewed due to his/her limited communication skills. [Note: Attempts were made by phone and email to contact and interview the VA's former case manager (CM2), but CM2 did not respond by the completion of this investigation.]

The VA's *Resident Placement Agreement* stated the following:

- The VA lived at the facility to receive services and support relating to his/her traumatic brain injury. The VA was blind in his/her right eye and deaf in his/her right ear. The VA might make sounds and smile when spoken to but was not consistently or reliably able to communicate his/her needs or wants.
- The VA liked watching movies, being read to, receiving hugs, and holding hands.

The facility was a single-family home where the SP was the live-in, primary caregiver. The SP also hired staff, who worked some daytime- and overnight-hours.

Facility documentation stated that the SP received training on the VA's support plans and the Reporting of Maltreatment of Vulnerable Adults Act; however, the training was not prior to or within the same month of the subsequent calendar year, which a violation of Minnesota Statutes, section 245D.09, subdivision 5, which states in part that the license holder shall ensure staff persons receive annual training as required regarding maltreatment reporting.

**Regarding the facility's use of the VA's trust fund for staffing:**

The G, the TM, the TCM, and the VA's *Irrevocable Asset Trust* provided the following consistent information:

- In 2006, the VA moved into the facility and received child foster care services. At that time, the P operated the facility and was the VA's primary caregiver.
- In 2011, the VA received a financial settlement relating to his/her traumatic brain injury, which was put into a special needs trust (*Irrevocable Asset Trust*) for the VA. [Note: According to the trustee's website, a trust is created to protect the assets of a physically or mentally disabled person while still allowing them to receive benefits from government sources. By putting the person's assets in trust, the person can receive funds without losing Medicare. The payout is at the discretion of the trustee and is meant to supplement the support the person receives from state and federal sources.]
- The VA's *Irrevocable Asset Trust* stated the following:
  - "... this Trust shall provide a system for fiscal management, administration and disbursement, advocacy, care, social and emotional guidance for [the VA] with regard to [his/her] special needs. The trust assets are to be used to supplement, not supplant, impair or diminish any benefits or assistance of any Federal, state, county, city, or other governmental entity for which [the VA] may otherwise be eligible or receiving...."
  - The trust listed examples of how the trustee might distribute the VA's trust funds. The trustee might distribute funds for the VA's medical needs, which might include medical, dental, vision and hearing care, psychological and psychiatric support services, including psychotherapy, attendant support services, therapy short or long term, residential or non-residential specialized medical/psychiatric care, supplemental health care, and other care all of which such services and products public benefit assistance programs provide no coverage.
- In July 2021, the SP took-over operation of the facility becoming the VA's primary caregiver and the P was no longer involved.
- In January 2022, the VA turned 18 years old and began receiving a Community Alternative Care (CAC) Waiver through the county to pay for 365 days per year of 24-hour adult foster care services, which included at least one staff person 24-hours a day. [Note: The VA's *RMS Worksheets* for July 2022 through July 2026 stated that the VA should receive 36 hours of shared direct care staff hours per day and 16 hours per night. The VA was the sole client at the facility between 2006 and 2023, when the license capacity increased to two.]
- The VA's trust was handled by at least two different trustees between 2011 and 2025. [Note: At the time of this investigation, the trustee was a private company in Alaska.] Also, between 2011 and 2025, the various participants of the VA's interdisciplinary team (IDT) (e.g., guardian, case manager, etc.) changed multiple times. By June 2025, the SP, the G, CM1, the TM, and the TCM were part of the VA's IDT and/or had some level of involvement with the VA's trust.
- In June 2025, the TM emailed the TCM asking what was going to happen when the VA's trust ran out of

money, which prompted questions and discovery that the trust was paying the VA's overnight staff wages at the facility and that the VA's county waiver was also paying the VA's overnight staff wages. For the county waiver, the amount paid was established each year by reviewing staffing needs on the VA's *RMS Worksheets*. For the trust, the SP submitted billing requests to a financial company, who specialized in payroll and was "designed exclusively for household employees being paid from private funding, such as, trusts" - [www.teamemployer.com](http://www.teamemployer.com). The financial company then submitted the billing requests to the trustee and the trustee paid the facility from the VA's trust. Based on calculations, since 2022 when the VA turned 18, the facility was inappropriately paid over \$500,000 from the VA's trust to cover staff wages, which were already paid to the facility by the county waiver.

The financial company provided records, which stated that there were seven staff people (S1-S6 and the SP), who submitted timecards between January 2022 (when the VA turned 18) through June/July 2025 (when the trust payments were halted). The records showed each staff's hourly pay rate and net pay every two weeks, which was direct deposited into unspecified accounts (most likely each individual person). The records did not state which shifts each staff person worked (e.g., morning, evening, and/or overnight) but that between January 2022 and June/July 2025 the trust's gross payout to P1-P6 and the SP was \$514,702.39.

The SP provided a staff roster from 2022 through 2025, which included S1-S6, plus two additional staff (S7 and S8), and their position titles, hourly rates of pay, and shifts typically worked and this stated:

- S1 worked mornings and some overnights.
- S2 was a licensed practical nurse and worked overnights.
- S3 was a licensed practical nurse and worked mornings and evenings.
- S4 and S6 worked overnights.
- The SP and S5 worked mornings, evenings, and overnights.
- S7 and S8 worked mornings and evenings.

The SP provided the following information:

- The SP said, "As far as I know, the county (wavier) didn't pay for overnight staff and so the trust was paying for overnight staff for [the VA] ... That is how I thought it worked. I was wrong."
- The SP said that the county waiver and the VA's trust were setup by the P and "grandfathered over" to the SP when s/he took over in 2021. Since that time, every two weeks, the SP submitted billing for the VA's overnight staffing hours to the financial company, who then billed the trust. The trust sent payments to the financial company, who then paid each staff person directly through a direct deposit into that staff's personal bank account. The financial company and the trust did not pay the SP directly for the staff wages, except for the timecards submitted by the SP for his/her own hours worked.
- The SP provided a copy of a December 2021 email that s/he sent to the financial company asking about staff wages. The SP asked if s/he should be getting paid as the asleep overnight staff and the financial company's response was, "Yes, you would want to record your time." The SP worked all shifts, including at times, the overnight shift.
- The SP never questioned the amount of money the facility received for the VA's care. "It made sense and

to be honest, there wasn't enough money." Because there were several adult foster cares in the community, which limited available staff, the SP used the trust money to pay staff wages and "be competitive" in obtaining qualified nursing staff for the VA's care. "It helped [the VA] get the care [s/he] needs at night."

- The SP provided a copy of a January 2024 email regarding a recent IDT meeting, which included CM1, the TCM, the VA's former guardian, and the VA's former trust manager. "Discussion was held regarding various staffing and the various levels of care in [the facility] ... There is an LPN that works part-time ... There is discussion of need for periodic RN assessment to consider medications, DME (durable medical equipment) replacement, DME maintenance, etc. ... [The trust manager] noted that [s/he] has authorized increased wages via [the financial company]."
- The SP provided copies of the *RMS Worksheets* for 2022 through 2026, which, the SP said were filled out annually for the county waiver and were "confusing" to the SP. "People tell me what to do (with the *RMS Worksheet*) and I'm like, 'Okay.' I just go with it." The SP had received help filling out the various forms from CM2 and a qualified developmental disability professional (QDDP), who formerly helped the SP as an unpaid consultant. [Note: This investigator spoke with the QDDP, who said that s/he did not provide any help with finances but helped the SP fill out paperwork.]
- The SP said that in June 2025, the VA's coordinated services and support plan had a different layout and "showed things better," which prompted questions about why the county waiver and the trust were each paying for the VA's overnight staffing. At that time, the trust payments for staff wages were immediately stopped.
- The SP said, "I had no intention to overbill [the VA] ... Nothing that happened was intentional. It was all a confusing accident." The SP said that s/he owned the facility, a single-family home, and did not own any other properties or own more than one vehicle. [Note: This investigator did not have access to the SP's personal financial information, including bank accounts, or personal expenditures.]
- The SP considered the VA to be "family" and was "distracted" to learn about the billing issue.

The P said that the VA's billing was setup a "long, long time ago" and it was "really confusing." The P never received a contract regarding the VA's trust. When the trust fund was setup in 2011, an unidentified attorney told the P to "go hire people right now." The P did not previously get paid for overnight staff and so the trust money was used to hire overnight staff. "The county knew all about it ... It wasn't a secret." The P said that there were times at the end of the fiscal year that s/he returned money to the trust because it was not used for staff payroll. The P had to "fill out a thing" to justify each trust expenditure and no one ever questioned anything. When the SP took over, the P showed the SP how to do things in the same way the P had been doing things.

Facility documentation included a July 2022 letter of "exhibits" to the VA's former trustee (Wells Fargo) from CM2, which listed out the VA's various trust expenditures, and included the following:

[The VA] is eligible to receive home-based nursing services through [his/her] waiver. In the past, these nursing services were available and provided through an agency ... For some time now, there has not been a pool of nurses available to provide these services and this situation continues with reference to hiring from an agency. Since June 2011, the Trust has paid [the facility] a monthly stipend to train and hire staff as needed to

ensure that [the VA] has qualified care givers for 24/7 care. This is mainly for nighttime staff as the waiver covers staff for the day and evening shifts.

[The VA's] trust is not designated to make payments for 'any medical care or other services or benefits' which could be paid through programs to which [s/he] is entitled 'as a handicapped person.'

It is clear to me (CM2) that [the SP] is invested in the care of [the VA] and competent in providing this care as well as the staff that are employed in the home.

CM1 said that s/he oversaw the VA's county waiver but did not have anything to do with the VA's trust. "I don't know what the trust does or doesn't do ... and it sounds like the trust didn't know what the waiver covered or didn't cover." When the billing concern was discovered, CM1 asked the SP if s/he noticed the VA was getting more money compared to other clients. The SP told CM1 that the VA was younger than the other clients and the other clients did not have trusts, and no one told the SP that s/he should not be billing the trust. The SP was continuing to do things the same way as the P. CM1 did not believe the SP was "maliciously taking" the VA's money and understood that the SP used the VA's trust money to pay for staffing. CM1 added that license holders are expected to navigate through several state and county systems and during the timeframe of 2022 through 2025, there were "significant changes to [the VA's] life and services." The facility's operation changed over to the SP; the VA turned 18, which made him/her eligible for different benefits and waivers and ineligible for others; the trustee and the guardian changed; and CM1 came onboard as the VA's adult case manager. "That is a lot. So, I really do see how things may have gotten confused by [the SP] when it came to billing ... It is an unfortunate situation. I do not think that [the SP] had malicious intent but rather was not privy to how the system was supposed to work for [the VA] and [his/her] services."

*Relevant Minnesota Statutes and Rules:*

Minnesota Statutes section 245D.04, subdivision 2, clause (8), states, in part, a person's service-related rights include the right to know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the person or other private party may have to pay.

Regarding the facility's use of the VA's trust fund for a wheelchair accessible van:

The G said that the SP used the VA's trust funds to lease a wheelchair accessible van for the VA. [Note: Information showed that the cost of the lease was around \$1200/month.] In June 2025, the G discovered the SP was using the VA's van to transport other clients. At that time, the VA's van lease was cancelled. The VA did not need it because his/her waiver paid for medical transportation.

The VA's *Irrevocable Asset Trust* listed examples of how the trustee might distribute the VA's trust funds. The trustee might distribute the VA's trust funds for social needs (e.g., for transportation, including a vehicle purchase and maintenance). "The Trustee may purchase an automobile for [the VA] if: it is used to provide necessary transportation for [the VA] or a member of [the VA's] household, as defined in 20 CFR 416.1218."

Facility documentation included a July 2022 letter of "exhibits" to the VA's former trustee (Wells Fargo) from CM2, which listed out the VA's various trust expenditures, including a modified vehicle. CM2 stated that in May 2022, the facility began leasing a van for the VA with a rear entry conversion with a manual ramp. "The rear entry makes transport so much easier for [the VA] because [s/he] rides in [his/her] wheelchair with [his/her] legs

extended” and at times parking lots did not give adequate space for side-entry accessible vehicles.

The SP said that s/he did not know the van should be solely used for the VA. The facility no longer had the van.

**Conclusion:**

**Regarding the facility’s use of the VA’s trust fund for staffing:**

Although the SP submitted billing requests to the VA’s trust for the VA’s staff needs which were also paid for by the county waiver, the SP said that s/he did not know s/he was double-billing and believed the county waiver did not pay for overnight staffing. The SP said that the VA’s trust was used to obtain qualified staffing for the VA; “It helped [the VA] get the care [s/he] needs at night.”

Information showed that the billing had been setup by the P prior to the SP’s employment and then “grandfathered over” to the SP when s/he took over from the P. The P said that s/he also believed the county waiver did not pay for overnight staffing. CM1 said that s/he did not know what the trust paid for and CM2 documented that the trust was paying a stipend to the facility for overnight staffing. CM1 added that license holders are expected to navigate through several state and county systems and during the timeframe of 2022 through 2025, there were “significant changes to [the VA’s] life and services.” The facility’s operation changed over to the SP; the VA turned 18, which made him/her eligible for different benefits and waivers and ineligible for others; the trustee and the guardian changed; and CM1 came onboard as the VA’s adult case manager. “That is a lot. So, I really do see how things may have gotten confused by [the SP] when it came to billing ... It is an unfortunate situation. I do not think that [the SP] had malicious intent but rather was not privy to how the system was supposed to work for [the VA] and [his/her] services.”

The financial company records, the SP’s staff roster, and the SP provided information that the VA’s trust was used to pay wages for staff persons who worked with the VA, including the SP, based on timecards for each person, and the money was directly deposited into each staff persons personal bank account. The SP did not have direct access to the trust and all funds/billing requests were submitted to a financial company who then submitted the request to the trustee who paid out the funds.

The VA’s trust paid over \$500,000 to cover staff wages, which were also paid to the facility by the county waiver. However, the VA’s trust was approved for the VA’s medical needs, which might include medical, dental, vision and hearing care, psychological and psychiatric support services, including psychotherapy, attendant support services, therapy short or long term, residential or non-residential specialized medical/psychiatric care, supplemental health care, and other care all of which such services and products public benefit assistance programs provide no coverage. The conduct of requesting financial coverage from two entities for the same services rendered and not ensuring the VA’s right to know in advance whether services were covered by insurance, government funding, or other sources was a violation of Minnesota Statutes section 245D.04, subdivision 2, clause (8).

Given that the VA’s trust could be used for supplemental health care (albeit, services and products that were not already covered by government assistance programs); that all information obtained showed that the VA’s trust was used to pay for the VA’s staffing needs; and that there was no information the SP willfully used the VA’s trust funds for the SP’s personal use; or that the SP’s conduct resulted in a detriment to the VA or included a failure to

use the funds for the benefit of the VA, there was not a preponderance of the evidence whether financial exploitation occurred.

Regarding the facility's use of the VA's trust fund for a wheelchair accessible van:

Although the SP used the VA's trust funds to lease a wheelchair accessible van, which was then used by other clients, the SP said that s/he did not know this was not okay. In addition, the trust, itself, stated, "The Trustee may purchase an automobile for [the VA] if: it is used to provide necessary transportation for [the VA] or a member of [the VA's] household." Without additional information to suggest the SP willfully misused the VA's funds to lease a van for reasons other than the VA's needs, there was not a preponderance of the evidence whether financial exploitation occurred.

It was not determined whether financial exploitation occurred (in the breach of fiduciary obligation recognized elsewhere in law, including pertinent regulations and contractual obligations . . . a person fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult. In the absence of legal authority a person: willfully uses, withholds, or disposes of funds or property of a vulnerable adult; obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult; and acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud).

**Action Taken by Facility:**

The facility completed an internal review and determined that policies and procedures were adequate and followed and that there was not a need for training or corrective action. The incident was not similar to past incidents involving the VA and/or the SP.

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

On January 27, 2026, the facility was issued a Correction Order for the violations outlined in this report.

A copy of this report was forwarded to the Office of Inspector General-Program Integrity Oversight Division for their review of possible financial fraud.

At the conclusion of this investigation, a law enforcement investigation into criminal fraudulent activity was ongoing. The Department of Human Services will review the information provided when the law enforcement investigation is completed and take any necessary action at that time.