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: 202600009

Date Issued: March 12, 2026

Name and Address of Facility Investigated:

REM Minnesota Community Services, Inc. - Palm
10411 Palm Street NW
Coon Rapids, MN 55448

REM Minnesota Community Services, Inc,
6600 France Ave. S., Suite 500
Minneapolis, MN 55435

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

License Number and Program Type:

1071811-H_CRS (Home and Community-Based Services-Community Residential Setting)
1071801-HCBS (Home and Community-Based Services)

Investigator(s):

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Suspected Maltreatment Reported:

It was reported that money was missing from three vulnerable adults (VA1, VA2, and VA3).

Date of Incident(s): July 2025 through January 2026

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 January 20, 2026; from documentation at the facility, law enforcement records, and bank records; and through eight interviews conducted with a facility staff person (SP), two facility supervisory staff persons (P1 and P2), VA1's, VA2's, and VA3's guardians (G1, G2, and G3), a representative payee for VA2 (RP), and VA3. Due to VA1's and VA2's abilities, they were unable to provide information for this investigation.

VA1's diagnoses included severe developmental disabilities and autism. VA1 had limited verbal abilities. VA1 enjoyed van rides, going out to eat, and attending camp.

VA2's diagnoses included profound developmental disabilities, autism, and tonic clonic seizures. VA2 was not able to communicate. VA2 enjoyed van rides, McDonald's, and music.

VA3's diagnoses included fetal alcohol syndrome and autism. VA3 liked cars, playing video games, and watching YouTube.

According to client plans, VA1, VA2, and VA3 each required assistance with management of cash and management of checking, savings, and other bank accounts. Staff persons needed verbal permission prior to any purchases greater than $500 for VA1 and VA2 and greater than $100 for VA3.

Bank records for VA1 showed the following unauthorized transactions:

- December 29, 2025- a Venmo money transfer to the SP for $25
- December 27, 2025- a Venmo money transfer to the SP's spouse for $50
- December 26, 2025- a Venmo money transfer to an unknown named party for $100
- December 26, 2025- a Venmo money transfer to an unknown named party for $20
- December 20, 2025- two Venmo money transfers to the SP for $50 each
- November 11, 2025- a payment to Walters Recycling for $105.31
- November 11, 2025- a Comcast/Xfinity purchase for $192.11
- November 3, 2025- a Venmo money transfer to the SP for $250
- October 27, 2025- a payment to Connexus Energy for $194.83
- October 21, 2025- a payment to Verizon for $779. 53
- October 20, 2025- two ATM withdrawals for $203 each, along with two non-ATM withdrawal fees for $3 each
- August 20, 2025- a payment to Verizon for $309.98

Bank records for VA2 showed the following unauthorized transactions:

- January 5, 2026- a Verizon payment in the amount of $354.73, with the SP's name referenced
- December 24, 2025- a Verizon payment in the amount of $706.27, with the SP's name referenced

Bank records for VA3 showed the following unauthorized transactions:

- November 3, 2025- a "point of sale withdrawal" to "RADET" for $999
- July 4, 2025- a "Cash App point of sale withdrawal" to an unknown named individual for $350
- July 4, 2025- a "Cash App point of sale withdrawal" referencing the SP's first name and last initial, for $450

P1 and P2 provided the following consistent information:

- On December 31, 2025, P1 needed to write a check for VA1 to attend a camp. The last bank statement P1 saw for VA1's bank account was from September 2025. The bank statements had been sent to the facility for years and P1 was unsure why they stopped sending them. P1 asked the SP to take VA1 to the bank several times to get copies of bank statements but the SP never did.

- P1 wanted to ensure there was enough money in VA1's account and called the number on the back of VA1's bank card. P1 was informed the account balance was $6.71. P1 selected to hear recent withdrawals from the account and learned there was a $779 charge for Verizon, along with charges for other utilities such as Comcast, Connexus, a waste management company, and another Verizon charge.

- At some point, that day P1 notified P2 that "a lot of money" was missing from the VA1's bank account. P1 obtained VA1's bank statements for September, October, November, and December of 2025, and found unauthorized purchases for phone and utility bills and Venmo cash transfers. VA1 was also missing $100 cash. P1 reviewed VA2's bank statements and found VA2 also had transactions that were unaccounted for.

- P2 made multiple attempts to meet with the SP to discuss the unauthorized transactions, but the SP had different reasons why the meetings could not take place.

- VA1 and VA2 did not have Venmo accounts or the ability to make purchases with their debit cards and required assistance from staff persons with making purchases.

- VA1 had a debit card and checkbook. VA2 had a checkbook. Approximately $40-50 cash was kept on hand for each VA1, VA2, and VA3. Cash was kept in individual wallets, and the wallets were kept in separate pouches in a binder for each individual. VA1's debit card was also kept in his/her binder for staff persons to use. The binders were kept in a locked office at the facility. Any additional cash and the checkbooks were kept in two safes in the locked office.

- The smaller safe contained VA1's and VA2's items and VA3's items were kept in the larger safe. The key for the larger safe was kept in a lock box in the office. The lock box only held one key and P1 never had a key to the smaller safe. The SP was the only person with the key for the smaller safe.

- At some point, the SP moved VA1's and VA2's items into the smaller safe from the larger safe. P1 stated the SP was not told to do that and was unsure why it was done.

- In July 2025, VA3's bank statements showed two unauthorized Venmo transactions to different individuals. The transactions listed first names but no last names. One of the names was the same as the

SP's name for $450. The other transaction was for $350. P1 did not suspect the SP at that time and stated s/he "trusted [the SP]." The facility did not make a maltreatment report at that time due to the bank reimbursing VA3 for the missing funds. In November 2025, a $999 "point of sale withdrawal" to "RADET" was seen on VA3's bank statement. The unauthorized transactions were reported to the bank and the bank reimbursed VA3 for the transactions.

- In February 2025, VA1 and VA2 were each missing cash from the safe. A maltreatment report was filed and the facility did an internal investigation and did not determine what happened to the money and reimbursed the money to both clients.

VA3 provided the following information:

- P1 discovered two unapproved CashApp transactions in the amounts of $350 and $450 on VA3's bank statement from July of 2025. VA3 never used CashApp. The transactions were reported to VA3's bank and the bank refunded the money to VA3's account.

- In November 2025, a $999 transaction to "RADET" showed up on VA3's bank statement. The transaction was reported to the bank and the money was refunded to VA3's account.

- The VA did not give anyone permission to use his/her debit card and was present for all purchases made with his/her card. The debit card was kept in a safe in the office at the facility. P1, the SP, and a maintenance worker were the only ones that had access to the safe.

G2 provided the following information:

- On an unspecified date, P1 notified G2 that VA2 was missing $750 from his/her bank account. P1 took VA2 to the bank to try to close the account but was unable to do so.

- VA2 had a representative payee that handled VA2's finances. G2 did not oversee any financial matters for VA2.

- VA2 did not own a cell phone and G2 did not authorize anyone to make payments to Verizon from VA2's account.

- A prior incident occurred in February of 2025, when $100 cash was discovered missing from VA2. The facility reimbursed VA2 for the missing funds.

G1 provided the following information:

- G1 gave permission to the facility and P1 to manage VA1's money on a day-to-day basis. The facility did not need to contact G1 unless the purchase was a large amount around $500. G1 did not give anyone permission to make Venmo transfers, ATM withdrawals, or make any utility payments from VA1's account.

- VA1's only bills were for room and board at the facility. VA1 did not have a cell phone or any utility bills. VA1 was unable to make purchases with a debit card, make a withdrawal at an ATM, or make Venmo transfers.

- G1 did not get copies of financial records and had not asked for them. G1 stated the facility had done a "good job" of managing VA1's money.

G3 provided the following information:

- G3 noticed two CashApp transactions from July 5, 2025, on VA3's bank account and brought it to P1's attention. One of the CashApp transactions was to someone that had the same name as the SP. P1 brought VA3 to the bank and filed a fraud claim.

- P1 later discovered a $999 "RADET" purchase and took VA3 to the bank to file a fraud claim. G3 stated the $999 charge was a fraud scheme that Visa had made them aware of. The bank reimbursed VA3 for that transaction.

- VA3 managed his/her finances with the assistance of P1. G3 looked over VA3's statements "once in a while" but otherwise was not involved in the finances.

The RP provided the following information:

- P1 informed the RP that the SP made purchases using VA2's personal account for $1000-$2000 and P1 was unable to close VA2's bank account. The RP did not give anyone permission to make any purchases from VA2's account.

- P1 told the RP that the SP took VA2 to the social security office a couple of months ago to get VA2 a social security card. Due to concerns of the SP having VA2's social security number, date of birth, and bank account information, the RP recommended G2 initiate a credit hold with the four credit bureaus to ensure no new accounts were opened in VA2's name.

- VA2 had a checkbook and debit card and only VA2 was authorized to make purchases. The RP sent a $200 check every month to VA2. The checks got deposited into VA2's bank account and were to be used for personal needs. The RP stopped payments from going into VA2's account until the issue was resolved.

The SP provided the following information:

- The SP assisted VA1, VA2, and VA3 with financial transactions. VA1 and VA3 had debit cards and VA2 had a checkbook. VA3 made purchases on his/her own but VA1 and VA2 needed assistance from staff persons.

- VA1's, VA2's, and VA3's debit cards, extra cash, and checkbooks were kept in a safe in the locked office. All staff persons had access to the office and the SP, P1, and a maintenance person had access to the safe. When staff persons took the clients on outings or shopping, P1 or the SP would get the clients' items out of the safe, so staff persons had access to the clients' cash, bank cards, and checkbooks.

- The SP stated s/he used to have CashApp but had not used it in two years.

- The SP said s/he accessed VA1's debit card while at the facility and linked it to the SP's Venmo account making multiple Venmo transactions to him/herself, family members, and a friend. The SP used VA1's debit card and VA2's bank account and routing number to pay the SP's utility bills. The SP denied that the accounts were still linked to any of his/her utility accounts or Venmo account.

- The SP denied taking any funds from VA3's bank account, taking any cash from the safe, or making ATM withdrawals from VA1's bank account for the SP's personal use. The SP acknowledged s/he did not have permission to use any of VA1's or VA2's money for his/her own benefit.

P1 and the SP were trained on the Reporting of Maltreatment of Vulnerable Adults Act.

Conclusion:

A. Maltreatment:

Information showed VA1, VA2, and VA3 had multiple unauthorized transactions from their bank accounts. The SP was the only person with access to the safe for VA1 and VA2, where their debit cards, extra cash, and checkbooks were kept. The SP was one of three people that had access to the safe where VA3's debit card was kept. VA1 had $2538.76 in unauthorized transactions from his/her bank account. The SP admitted to taking $2126.76 of those missing funds for personal use. VA2 had $1061 in unauthorized transactions from his/her bank account and the SP admitted to taking all of those missing funds for personal use. VA3 had $1799 in unaccounted transactions from his/her bank account. The SP denied being responsible for the two CashApp transactions including one transaction that referenced the SP's first name and last initial and the "RADET" purchase from VA3's account. Although the SP denied making any of the transactions on VA3's account, since the SP admitted to taking funds from VA1 and VA2, that one of VA3's transactions referenced the SP's first name and last initial, and that the SP was one of only three people that had access to VA3's debit card, it was likely the SP made the two CashApp transactions totaling $800.

Given that the SP admitted transferring money from the bank accounts of VA1 and VA2 without permission for his/her own personal financial gain, and likely transferred money from VA3's bank account as well, there was a preponderance of the evidence that VA1's, VA2's, and VA3's funds were willfully used or withheld, in the absence of legal authority.

It was determined that financial exploitation occurred (in 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 was trained on the Reporting of Maltreatment of Vulnerable Adults Act. The SP linked VA1's debit card to the SP's Venmo account making multiple Venmo transactions to him/herself, family members, and a friend. The SP used VA1's debit card and VA2's bank account to pay the SP's utility bills. The SP was responsible for maltreatment of VA1, VA2, and 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 the SP was responsible was "recurring" maltreatment because the SP made financial transactions from VA1's, VA2's, and VA3's bank accounts on more than one occasion.

The SP was disqualified from providing direct contact services.

Action Taken by Facility:

The facility completed an *Internal Review* and determined support plans, program policies, and procedures were adequate but not implemented as applicable. P1 received corrective action and was retrained on management of individuals' funds, and VA2's plans were updated to include proactive strategies for each area of risk.

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.

In addition, it was determined that facility mandated reporters had knowledge of the alleged incident involving VA3's funds in July of 2025 and did not report the incident as required. The license holder was issued a Correction Order for failure to report maltreatment.