

## V.I. Health Department Failures Lead to DOJ Referral of \$17,005 in Questionable Eldra Schulerbrandt Withdrawals

**An Inspector General audit found V.I. Department of Health failures in oversight, recordkeeping and account access at Eldra Schulerbrandt, including \$17,005 in questionable withdrawals, \$2,652 in poorly controlled cash and \$767 owed to former residents.**

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The V.I. Inspector General will refer \$17,005 in questionable withdrawals from two Eldra Schulerbrandt Residential Facility residents' bank accounts to the V.I. Department of Justice after an audit found no documented justification or reimbursement for the transactions. The report also identified inadequate controls over \$2,652 in residents' cash and cash equivalents, including \$767

belonging to five former residents.

#### **\$17,005 in Withdrawals Questioned**

Residents' bank accounts were not initially part of the surprise cash count. Auditors expanded their review after learning that one resident's account had reportedly been used to pay \$6,000 toward another resident's medical procedure.

The V.I. Department of Health managed bank accounts for at least six of the 22 residents living at the facility when the cash count was conducted. Three accounts were under court supervision, while three were managed solely by the department.

Because the three accounts controlled only by the Department of Health were not subject to judicial review, auditors determined that they presented a higher risk of fraud and examined their activity.

For one resident, the report identified questionable withdrawals totaling \$15,433. It described five suspicious withdrawals and specifically listed transactions of \$1,660 on November 6, 2023; \$2,125 on November 7, 2023; \$6,000 on January 18, 2024; and \$5,648 on February 8, 2024.

None of those withdrawals was used to meet the facility's requirement that residents pay 80 percent of their monthly income toward services including room and board.

An internal DOH incident report questioned the use of the resident's account to pay for another resident's medical procedure. According to the audit, the former assistant director said directors had approved the transaction, but the Inspector General was not provided with documentation supporting that approval.

One director reportedly said the Department of Finance had reimbursed the money. Auditors found no evidence that the resident's account had been repaid.

A second resident's bank records showed an unsupported withdrawal of \$1,572 on January 16, 2024. The Department of Health did not provide documentation explaining the transaction.

No suspicious activity was identified in the third account examined.

The Inspector General said the use of one resident's account to pay another resident's medical expenses, combined with the broader failure to account for residents' money, raised concerns about the department's fiduciary obligations, unauthorized use of funds, possible embezzlement and the potential financial exploitation of an elderly resident.

The transactions will be referred to the V.I. Department of Justice for further investigation into their legality.

#### **Audit Followed Surprise Cash Count**

The findings resulted from a surprise cash count conducted on July 28, 2025, and a limited examination of residents' bank accounts covering the period from 2022 through 2025.

The audit sought to determine whether the V.I. Department of Health properly accounted for and managed cash and other cash equivalents received on residents' behalf and whether bank accounts

controlled solely by the department were adequately managed.

The Eldra Schulerbrandt Residential Facility provides mental-health services to adults with acute mental illness who require intermediate, long-term or transitional care.

Services include room and board, medication management, medical and psychiatric evaluations and supervision, discharge planning, home visits for discharged clients, banking assistance, court appearances and security.

The facility can accommodate up to 32 residents. At the time of the cash count, 22 people lived there — 11 under court orders and 11 who had been admitted voluntarily.

The facility also serves as representative payee for some residents who receive Social Security benefits and are considered unable to manage those payments. Their Social Security checks are deposited directly into bank accounts managed by Department of Health officials.

Before the cash count, the Inspector General found that the department had not established policies specifically governing the management of residents' funds. Its existing billing policy, effective September 1, 2019, primarily addressed charges for services.

Under that policy, residents were billed 80 percent of their monthly income for services provided at the facility. The remaining 20 percent was to remain in each resident's account for medication copayments and personal purchases.

The policy required proof of bank withdrawals through receipts or stamped withdrawal slips signed and dated by the person making the withdrawal. For court-mandated residents, copies of income and expenditure records and receipts were required to be included in reports submitted to the court.

On July 30, 2025, two days after the surprise cash count, the Department of Health retroactively approved three additional policies addressing representative-payee responsibilities, monthly reconciliation of residents' funds and the management of Social Security benefits after a resident's death or discharge.

The policies carried effective dates of July 25 and July 28, 2025.

The Inspector General noted that no other cash-count audit of the facility had been completed during the previous five years.

#### **\$2,652 Found in Cash and Cash Equivalents**

Auditors found \$2,652 belonging to current and former residents, including \$2,371 in cash, \$275 in money orders and a \$6 check.

Of that amount, \$2,155 was stored in a secure location with limited staff access. Another \$497 was kept in a locked drawer accessible to multiple employees who were not responsible for managing residents' money.

The funds were divided among 29 envelopes labeled with residents' names. Three residents had more than one envelope.

During 2024 and 2025, the Department of Health managed funds for at least 27 residents. By the time of the count, four had died, one had been discharged and 22 remained at the facility.

Sixteen current residents had \$1,885 in cash and cash equivalents stored in 24 envelopes. Six current residents had no cash at the facility.

Another five envelopes held \$767 belonging to former residents. Of that amount, \$759 belonged to four people who died during 2024 and 2025, while \$8 belonged to a resident discharged in 2024.

The Inspector General found that the former assistant director responsible for managing the funds had not maintained adequate records showing where the money came from, how it was spent, the remaining balances or the dates of transactions.

The source of money in 24 of the 29 envelopes was not documented. Only nine envelopes contained receipts, and those receipts did not reconcile with the cash balances.

In one instance, an envelope's records showed \$168, while auditors counted \$174.

Auditors found no evidence that residents' cash had been reconciled as early as 2023 or before the assistant director retired in 2024. Department officials conducted an inventory of cash on hand one month after the employee's departure.

Because of the missing documentation, the Inspector General said it was impossible to reconcile the envelopes or confirm that their balances were accurate.

Department officials believed the money may have come from family members, Covid-19 stimulus payments or residents' Social Security checks. One official said the money had been used for residents' daily and personal needs.

As of February 2026, the Department of Health had not distributed the \$767 to the estates of the four deceased residents or to the discharged resident, despite adopting procedures for such situations in July 2025.

#### **Residents and Officials Lost Account Access for One Year**

The audit also found that upper-level Department of Health management did not require financial reports covering residents' cash balances, bank reconciliations or other financial activity.

Two senior directors said they did not receive financial reports from the former assistant director and were unsure whether such reports were required.

Financial records were prepared for court-mandated residents and submitted to the courts. Residents whose accounts were controlled solely by the Department of Health did not receive that additional oversight, increasing the risk of fraud, according to the audit.

Department officials and residents also went without access to the bank accounts for approximately one year because signatory authority was not transferred before the assistant director retired in 2024.

The Department of Health hired a replacement in 2025. The first attempt to change the authorized signatures was made through a letter submitted to the bank on May 13, 2025, but the changes were

not completed until January 2026.

Although a department official said gaining access could take as long as one year, the Inspector General found that the Department of Health delayed providing the required documents to the bank.

During the period without access, the department could not collect the 80 percent service fee from residents, while residents could not access their money to purchase needed items.

The department covered residents' needs in the interim. Some employees used personal funds for items including snacks.

Several employees said they were not reimbursed. One employee said expenses below a certain amount were not submitted for reimbursement, while two others considered the money they spent to be donations to residents.

One official acknowledged that responsibility extended across the department, including management, and said account authority should have been transferred before the former assistant director departed.

#### **Six Corrective Actions Implemented**

The Inspector General issued eight recommendations requiring the Department of Health to strengthen the accounting, supervision, reconciliation, reporting and security of residents' money; ensure timely access to funds; establish a process for money belonging to deceased residents; and determine how unauthorized withdrawals should be reimbursed.

The Department of Health submitted its response on June 29, 2026.

The department reported implementing new resident ledgers, documentation requirements for deposits and expenditures, monthly account reconciliations, management reviews, compliance monitoring, staff training and procedures for transferring signatory authority.

Access to resident funds is now limited to the director of Behavioral Health and two financial-services employees, according to the department's corrective action plan.

The Inspector General classified the first six recommendations as resolved and implemented.

The recommendation concerning money belonging to deceased residents remains unresolved. The Department of Health said those funds had been deposited into a departmental account for safekeeping while it researches how to legally transfer the money to a guardian or estate.

The second unresolved recommendation concerns reimbursement for any unauthorized withdrawals. The department said it would coordinate with its Financial Services Division, the Department of Finance and the Office of Management and Budget regarding reimbursement and other corrective financial action.

The Department of Health set July 24, 2026, as the anticipated completion date for both outstanding matters.

The report was distributed to the Department of Health, the governor's and lieutenant governor's offices, the Office of Management and Budget, the V.I. Department of Justice, the 36th

Legislature, the legislative post auditor and the Virgin Islands delegate to Congress.

Federal recipients included the U.S. Attorney's Office and the Federal Bureau of Investigation

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