Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL262096405M
Compliance #: HL262095149C

Date Concluded: November 26, 2025

Name, Address, and County of Licensee Investigated:
Brightstar Care of St. Paul
5862 Blackshire Path
Inver Grove Heights, MN 55076
Ramsey County

Facility Type: Home Care Provider

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) financially exploited the client when the AP accepted over $2000 from the client in the form of tips, payments for dental and veterinary bills, a family vacation, and rent.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP accepted tips and bonuses from the client and client's family member. The AP denied the client helped pay her rent, dental bills, veterinary bills, and for family vacation. The AP offered to pay money back but did not do so.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident records, bank records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The client received comprehensive home care services in their home. The client's diagnoses included dementia. The client's services included assistance with activities of daily living, meals, and medication reminders. The client's assessment indicated the client had deficits in short-term memory, was forgetful and confused, and had a history of falls.

An incident report indicated when the AP began working with the client, he wanted to give her occasional tips of $20-$25. Initially, the AP declined the tips, stating it was against policy, but eventually she began to accept the tips. After the AP provided two weeks of respite services for the client, the client's family member gave her a tip of $300. After that, the family member felt comments from the AP became increasingly manipulative. The AP mentioned being in pain and unable to work much, needing a dental procedure she could not afford, and having a sick dog she could not afford to treat. The family member believed the client gave the AP around $100-200 to cover the AP's dental bill. The client paid the AP another $200 to cover a veterinary bill. The AP then expressed she could not afford to go on vacation and missed her mother. The client provided the AP with $500 to take a trip to Chicago. After that, the client paid $870 at least twice to cover the AP's rent.

The incident report indicated although the client's family member was aware the client was giving money to the AP, she did not want to go against the client's wishes, as it was his money and she wanted to support his independence. However, it reached a point to where the client's family member felt the AP was being manipulative and taking advantage of the client's dementia. The AP offered to repay the money but had not done so. The AP's employment with the agency was terminated.

The client's family member said she did not keep receipts or most records of the client's bank withdrawals, but she did provide bank records indicating one withdrawal of $870.00, which she said was to cover the AP's rent. The client's family member provided another statement indicating withdrawals of $550 and $500 five weeks apart, which she said went to the AP's various expenses.

An incident investigation checklist indicated the AP accepted unauthorized gifts from the client. Proper policies and procedures were not followed as the AP did not report gifts offered by the client or gifts accepted by the AP from the client, with an amount exceeding $3000. The AP's employment was terminated.

When interviewed, a supervisor said the client's family member reported a concern about financial exploitation. The family member said it began with the AP accepting tips and thank you gifts from the client. Eventually, the client's family member felt the AP was manipulating the client by telling him "sob stories" like she could not pay her rent, or she could not afford veterinary bills, or she could not afford to pay her rent and such. The client's family member did not have receipts, as she would just withdraw cash from the client's bank account per his request. Sometimes the money was for something specific (such as rent, dental bills, veterinary

bills, etc.), and other times the client said he just wanted to give the AP some money. The client felt he needed to give the AP sums of money to help her with her bills and finances. The agency discussed the situation with the AP and terminated her employment. The AP denied accepting any money from the client. The AP then did admit to receiving a card with some gift cards in it as a thank you for working some extra shifts one week.

When interviewed, a family member said the client developed dementia and she secured home health aide services for him. The family member oversaw the client's finances, and the client would frequently tell her he wanted to give the AP monetary tips for helping him out. The tips were in amounts of $20 to $25. The family member said she was aware of the tips and did not realize staff were not supposed to accept money or gifts from clients. As such, she did not record or keep receipts of various purchases made on the AP's behalf. The amounts of money got larger and larger, and the client's family member started to feel that the AP was emotionally manipulating her and the client. The client would instruct the family member to take certain amounts of money from his bank account, such as $300, $500 for veterinary and dental bills, and finally $870 for the AP's rent. The AP would tell the client of her struggles, and the client wanted to help her. The client's family member estimated over the course of time he had given the AP over $3000 total. The family member chose not to file a police report.

When interviewed, the AP said she never accepted money from the client. The AP denied accepting money for dental bills, veterinary bills, rent, or a family vacation. She declined to accept tips from the client, but the client's family member said the AP was insulting the client by not accepting the tips he offered her. The AP did say the client surprised her once with a card that contained $100 cash in it, which she accepted. But that was the only money she received. When asked if she had received any bonuses for providing respite care, the AP then remembered she received $300 once for walking the dog. The AP believed she was set up.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) 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;
(3) 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; or

(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No, unable to interview due to cognitive status.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed an internal investigation of the complaint. The AP is no longer employed by the provider.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Roseville City Attorney
Roseville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26209	A. BUILDING: _____ B. WING _____	C 10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTSTAR CARE OF ST PAUL	5862 BLACKSHIRE PATH INVER GROVE HEIGHTS, MN 55076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDERCORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL262095149C/#HL262096405M On October 23, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 350 clients receiving services under the provider's Comprehensive Home Care license. The following correction order is issued/orders are issued for #HL262095149C/#HL262096405M, tag identification 0325.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment	0 325		

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0 325	Continued From page 1 be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was/were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	0 325		