

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL278343123M
Compliance #: HL278341877C

Date Concluded: August 6, 2026

Name, Address, and County of Licensee

Investigated:

Embrace Home Care LLC
204 South Washington Avenue #100
Albert Lea, MN 56007
Freeborn County

Facility Type: Home Care Provider

Evaluator's Name: Michele Larson, 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), a caregiver, financially exploited two clients (client #1, client #2) when she took money from them while providing cares in their homes.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment of client #1 and client #2. Review of client #1's phone records indicated there were several calls made between client #1 and the AP during the times the AP received money from client #1. When interviewed, client #1 stated the AP asked him for \$1,000 and the AP admitted she took the \$1,000. In addition, after client #1's services were discontinued, the AP remained in contact with client #1 after instruction to cease communication by the home care provider. The AP received an additional \$1,700 in cash from client #1 during the time she was still employed by the home care agency. During client #1's investigation it was discovered the AP was named as an AP in another financial exploitation allegation five months earlier involving client #2. Client #2 reported AP stole \$1,500 cash from

her and borrowed money several times but never repaid the money. Review of client #2's bank records showed the \$1,500 cash withdrawal and other large money withdrawals from client #2's bank account occurred only on dates and times the AP was scheduled to provide services in client #2's home. The AP used her position as a caregiver to establish trust to solicit and take their money.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The AP was interviewed. Both client #1 and client #2 were interviewed as well as their family members. The client's family members were interviewed. The investigation included review of the client's records, facility internal investigations, facility incident reports, AP employee file, AP schedules, client #1's clinic record, phone records, and related facility policy and procedures.

Client #1

Client #1 received basic home care services in his home. The client #1's diagnoses included depression, anxiety, stroke, and left-sided hemiplegia (total or partial paralysis of the left side of the body). Client #1's service plan included assistance with meal preparation, housekeeping, and laundry. Client #1's assessment indicated he was alert and oriented and able to make his needs known. Client #1's vulnerability assessment indicated the client was susceptible to financial exploitation. Client #1 used a cane to walk.

An incident report indicated family member #1 overheard client #1 talking with a female on the phone. The female asked client #1 if he could do that for her and client #1 responded yes. When asked, client #1 stated the AP called and asked him for \$1,000. Family member #2 told client #1 it was inappropriate for the AP to ask him for money. Client #1 agreed he would not give the AP any money. Family member #2 called the home care agency to let the agency know they no longer wanted the AP to provide services to client #1. The following day the AP was removed from client #1's schedule.

The internal investigation report indicated the following morning the AP was brought to the home care agency to discuss the incident. The AP stated client #1 offered her the \$1,000 after she told client #1 she had tax-related financial issues. The AP stated she would "never take money from a client." Leadership advised AP to cease all communication with client #1 and the AP agreed. Leadership reviewed professional boundaries with the AP.

No further action was taken by the home care agency and the AP was allowed to continue to work unsupervised in client's homes.

Review of client #1's bank statement indicated three weeks later client #1 withdrew \$1,000 cash from his bank account.

Review of client #1's phone records indicated during the time the AP asked for \$1,000 there were multiple calls back and forth between them and an increase in both the volume of calls

and phone duration times around the time the AP first asked client #1 for \$1,000 and when client #1 withdrew the money.

Review of information obtained from law enforcement indicated the AP went to a casino and gambled close to \$1,000 the day client #1 withdrew \$1,000 from his bank account.

In addition, review of client #1's bank statement indicated client #1 withdrew \$1,700 cash from his bank account one month later. Review of client #1's phone records during that time showed an increased volume of calls and longer phone duration times between client #1 and AP.

Although the AP no longer provided services to client #1 at the time she received \$1,700 from him, the AP still remained employed as a caregiver for the home care agency.

When interviewed by law enforcement, the AP stated she and client #1 became close during the time she provided services to him and stated client #1 "gotten to be a little infatuated with me." When asked about the \$1,000, the AP stated client #1 stated he would help AP with taxes as well as other things the AP did not elaborate on. The AP insisted "that was a thing just between me and him," and stated the money was a loan.

When interviewed, leadership stated during the facility investigation the AP told them client #1 offered her money and stated she would never take or borrow money from a client. Leadership stated the AP broke professional boundaries.

When interviewed, family member #1 stated client #1 was very empathetic with people's struggles and liked the attention AP gave to him. Family member #1 stated one evening at around 5:30 p.m. client #1 received two phone calls from AP. The first call family member #1 heard the AP ask client #1 if he could "do that" for her to which client #1 replied yes. Minutes later, the AP called back and asked client #1 when she could "get it," which client #1 replied two days later. Family member #1 stated she told family member #2 who confronted client #1. Client #1 admitted the AP called and asked him for \$1,000. Family member #1 stated when they reported client #1's incident to the home care agency, leadership stated they would file a report with the state but stated there was nothing more they could do.

When interviewed, family member #2 stated facility leadership told them the AP was no longer employed at their agency after client #1's incident.

When interviewed, client #1 stated the AP asked him in person for the money. Client #1 stated he was a good hearted person and thought the AP was honest and trustworthy.

When interviewed, the AP stated she never asked client #1 for money stating he wanted to help her out. The AP stated she told law enforcement she took the \$1,000 from client #1, stating "I'm not going to lie about it. Client #1 calls me and I don't call him."

Client #2

Client #2 received comprehensive home care services in her home. Client #2's diagnoses included major depression and anxiety. Client #2's assessment indicated she had a history of abuse and was susceptible to being abused by others. Client #2's care plan indicated she required assistance with medication set-up, medication reminders, showers, hair and oral care, and meal preparation.

An incident report indicated approximately five months prior to the incident with client #1, client #2 told the home care staff member that the AP took \$1,500 cash and borrowed additional money multiple times but never repaid the funds. The staff member reported the incident to leadership.

An internal investigation summary indicated client #2 reported in addition to taking client #2's money, the AP called afterwards instructing client #2 to say client #2 withdrew the money for herself, not the AP. When interviewed, the AP stated at a previous date she drove client #2 to the bank drive-through to withdraw \$1,500; stating client #2 mentioned needing the money to pay for rent, a new air conditioner, and vehicle tabs. The AP denied she took any money from client #2 and stated she called client #2 because she was concerned about client #2's anxiety about a recent home sale and change in guardianship. When interviewed, client #2's professional guardian stated a large money withdrawal occurred. The facility concluded its investigation the following day concluding there was no evidence the AP took the \$1,500 and borrowed money from client #2.

Review of client #2's bank records indicated the \$1,500 and several fairly large cash withdrawals occurred only on dates and times the AP was scheduled to provide services in client #2's home.

The facility took no disciplinary action with the AP and the AP resumed providing unsupervised cares to clients. In addition, review of AP's schedule indicated she continued to provide cares to client #2 after the incident.

When interviewed, a home care agency staff member stated she believed client #2 was truthful when client #2 told her the AP took money from her.

When interviewed, client #2's family member stated he re-entered client #2's life after client #2's landlord alerted him regarding concerns about client #2's care and treatment. Client #2's family member stated he became suspicious of AP and conducted his own investigation into client #2's cash withdrawals. Client #2's family member stated in addition to the \$1,500 cash withdrawal there were several cash withdrawals for \$300, \$200, and \$100 dollars, stating he matched the withdrawals with the days AP was with client #2 as well as reviewing receipts when AP ran errands with client #2 stating the receipts were much less than the amount of cash withdrawn from client #2's account. Client #2's family member stated the first day he talked with AP he knew something was wrong, stating the AP appeared "guilty."

When interviewed, client #2 stated the AP was the only one who took her to the bank, stating the AP would say, "We need to go to the bank to get some money." Client #2 stated the AP would drive up to the bank teller window and withdraw money, put it in her purse, and not give it to client #2. Client #2 stated she did not understand why she and the AP went to the bank all the time. Client #2 stated she was not a very smart person but did know when she was being used. The AP made all the decisions to go to the bank and take out money.

When interviewed, the AP denied she took any money from client #2. The AP stated she ran errands with client #2 once a week and stated client #2's bank cash withdrawals were never over \$100 when they ran errands, stating it was usually for minimal necessities. The AP stated she recalled she was not to accept money and gifts from clients.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated for client #1 and client #2.

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: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility talked to the AP about professional boundaries.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. 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>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

Freeborn County Attorney

Albert Lea City Attorney

Freeborn County Sheriff's Office

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H27834	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/21/2026
NAME OF PROVIDER OR SUPPLIER EMBRACE HOME CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 204 SOUTH WASHINGTON AVE, SUITE 100 ALBERT LEA, MN 56007		
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0 000	Initial Comments *****ATTENTION***** HOME CARE PROVIDER CORRECTION 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: HL278341877C/HL278343123M On May 21, 2026, 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 72 clients receiving services under the provider's Comprehensive Home Care license. The following correction orders are issued for HL278341877C/HL278343123M, tag identification 325, 880.	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 be free from physical and verbal abuse, neglect,	0 325			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 325	Continued From page 1 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 two of two clients(s) reviewed (C1, C2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	0 325			
0 880 SS=G	144A.4791, Subd. 11 Client Complaint and Investigative Process (a) The home care provider must have a written policy and system for receiving, investigating, reporting, and attempting to resolve complaints from its clients or clients' representatives. The policy should clearly identify the process by which clients may file a complaint or concern about home care services and an explicit statement that the home care provider will not discriminate or retaliate against a client for expressing concerns or complaints. A home care provider must have a process in place to conduct investigations of complaints made by the client or the client's representative about the services in the client's plan that are or are not being provided or other items covered in the client's home care bill of rights. This complaint system must provide reasonable accommodations for any special needs of the client or client's representative if	0 880			

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0 880	Continued From page 2 requested. (b) The home care provider must document the complaint, name of the client, investigation, and resolution of each complaint filed. The home care provider must maintain a record of all activities regarding complaints received, including the date the complaint was received, and the home care provider's investigation and resolution of the complaint. This complaint record must be kept for each event for at least two years after the date of entry and must be available to the commissioner for review. (c) The required complaint system must provide for written notice to each client or client's representative that includes: (1) the client's right to complain to the home care provider about the services received; (2) the name or title of the person or persons with the home care provider to contact with complaints; (3) the method of submitting a complaint to the home care provider; and (4) a statement that the provider is prohibited against retaliation according to paragraph (d). (d) A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client's representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to thoroughly investigate complaints from client families for suspected financial exploitation by unlicensed personnel's (ULP)-I for two of two clients (C1, C2) records reviewed. This deficient practice had the potential to affect all clients as ULP-I continued to work unsupervised after allegations were made with other client's.	0 880			

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0 880	Continued From page 3 This practice resulted in a level three violation (a violation that harmed a client's health or safety, or a violation that had the potential to cause more than minimal harm to the client) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C2 C2's record was reviewed. C2 began receiving home care services on July 1, 2025. C2's diagnoses included major depression and anxiety. C2's assessment dated July 1, 2025, indicated C2 had a history of abuse and was susceptible to being abused by others. C2's care plan dated July 8, 2025, indicated C2 required assistance with medication set-up, medication reminders, showers, hair care, oral care, and meal preparation. C2's incident report dated October 20, 2025, at 11:00 a.m. indicated C2 told ULP-H that ULP-I stole \$1,500 cash from her along with other money but never repaid C2. C2's internal investigation summary dated October 20, 2025, indicated C2 reported ULP-I borrowed \$1,500 cash from her. ULP-I would call C2 and instruct C2 to say C2 withdrew the money herself. When interviewed, ULP-I stated she previously drove C2 to her bank to withdraw \$1,5000. ULP-I stated C2 mentioned she needed the money for rent, an air conditioner, and vehicle tabs. ULP-I stated she saw C2 put the money in her purse and denied taking any money from C2. ULP-I stated she called C2 because C2 was	0 880			

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0 880	Continued From page 4 anxious about her previous home sale and change of guardianship. C2's professional guardian (G)-F reviewed C2's bank account activity and noted the only large withdrawal occurred in August 2025. The licensee concluded its internal investigation the following day declaring there was no evidence to support C2's allegation ULP-I took and borrowed money from C2. Review of ULP-I's schedule dated October 20, 2025 through November 29, 2025, indicated ULP-I continued to work several shifts in C2's home unsupervised. On November 20, 2025, family member (FM)-G stopped C2's services with the licensee when FM-G became C2's legal guardian. C2's record lacked evidence the licensee adequately assessed the risk of ULP-I continuing to provide cares to C2 and other clients and lacked evidence meaningful action was taken to prevent potential further financial exploitation. During an interview on June 10, 2026, at 12:07 p.m., FM-G stated on July 2, 2025, C2's landlord tracked FM-G down on the internet to let him know C2 needed help due to C2's treatment and care while under professional guardianship and concerns about a licensee staff member. FM-G stated he conducted his own investigation and determined ULP-I took money from C2. FM-G stated he attempted to set up a meeting with owner (OW)-C, G-F, and county adult protective services but stated no one wanted to talk to him stating, "they didn't feel a need to talk to me." During an interview on June 11, 2026, at 10:15 a.m., OW-C stated FM-G did request a meeting	0 880			

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0 880	Continued From page 5 with but stated she refused to meet with FM-G after FM-G kicked her out of C2's apartment. OW-C stated she was uncomfortable talking to FM-G stating FM-G was angry with what occurred with C2, the county, and the licensee, stating FM-G felt like we were all part of the problem. C1 C1's record was reviewed. C1 began receiving home care services on September 12, 2025. C1's diagnoses included stroke with left-sided paralysis (hemiplegia) and left-sided muscle weakness (hemiparesis). C1's care plan dated October 7, 2025, indicated C1 required assistance with dressing/undressing, meal preparation, medication reminders, housekeeping, and laundry. C1 used a cane for walking. C1's incident report dated March 29, 2026, indicated FM-D called the licensee to complain about ULP-I after FM-A overheard ULP-I ask C1 to give her \$1,000 during a phone call. OW-C indicated she would address FM-D's complaint the following day and indicated ULP-I would no longer be providing services to C1 in his home. The next day ULP-I was removed from C1's schedule and the licensee submitted a Minnesota Adult Abuse Reporting Center (MAARC) report. OW-C told FM-D that FM-D's complaint was addressed. C1's internal investigation summary dated March 30, 2026, at 11:00 a.m., ULP-I stated C1 offered to give her money after she told C1 she was experiencing "tax-related" financial issues. ULP-I stated C1 was the one who initiated all the phone calls between them and she felt it was appropriate to reply to C1's phone calls. ULP-I denied requesting \$1,000 from C1 stating, "I	0 880			

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0 880	Continued From page 6 would never take money from a client." OW-C and registered nurse (RN)-E advised ULP-I to cease all communication with C1 and his family outside of work-related communication. Although the licensee determined there was no evidence ULP-I requested money from C1, there were concerns regarding professional boundaries that were addressed and ULP-I was issued a verbal warning. After the incident ULP-I continued to provided unsupervised cares to other clients in their homes. C1's internal investigation lacked evidence it conducted a thorough investigation including interviewing C1, FM-A, and FM-D. During an interview on May 28, 2026, at 9:00 a.m., FM-D stated after C1's incident OW-C told her ULP-I was no longer working for the licensee and told FM-D the licensee could only control what ULP-I did during work hours, not after hours. FM-D stated she was appalled when OW-C told her she had ULP-I go work in another client's home before they talked to her about C1's incident. During an interview on June 11, 2026, at 10:15 a.m., OW-C stated they were going to terminate ULP-I after C1's incident but ULP-I told them she would never take C1's money, stating they needed to follow employment laws and could not accuse ULP-I. OW-C stated she wished FM-D reached out to her but stated she did not reach out to FM-D after the incident. The licensee policy titled Employment Handbook, Section Employment Practices/Employee Misconduct dated January 11, 2025, indicated employees of the licensee were expected to maintain professionalism, honesty, and ethical	0 880			

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0 880	Continued From page 7 conduct while representing the licensee. Any act of misconduct whether during work hours, at a client's home, or while conducting licensee business may result in disciplinary action up to and including termination of employment. Examples of gross misconduct included financial abuse of a client theft or misuse of client or agency property. Consequences for gross misconduct typically resulted in immediate termination and may be reported to the Minnesota Department of Health (MDH) or appropriate authorities as required by law. TIME PERIOD TO CORRECT: Seven (7) days.	0 880			