



*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL399135504M

**Date Concluded:** October 30, 2025

**Compliance #:** HL399132779C

**Name, Address, and County of Licensee**

**Investigated:**

Cornerstone Caregiving  
2711 West Superior Street #206B  
Duluth, MN 55806  
St. Louis County

**Facility Type:** Home Care Provider

**Evaluator's Name:**

Katherine Barnhardt 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 stole the client's bank card and fraudulently charged more than ten-thousand dollars to the card.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP stole the client's bank card the first day the AP worked in the client's home and fraudulently used the bank card to pay tuition expenses and order online items.

The investigator conducted interviews with agency staff members, including administrative staff and nursing staff. The investigator contacted law enforcement, interviewed the client and a family member. The investigation included review of the client record(s), home care records, financial records, internal investigation documents, incident reports, personnel files, staff schedules, law enforcement report and related policy and procedures.

The client received comprehensive home care services in their home. The client's diagnoses included falls and blindness. The client's service plan included assistance with toileting, guidance for mobility, meal prep and housekeeping. The client's assessment indicated the client was alert and could make needs known, however, had anxiety, a fear of falling and required guidance for mobility in the home.

The client's record indicated due to a recent fall and blindness a home care agency was hired to assist with daily services. The client's record indicated the AP provided services in the client's home three times. The client's record indicated an allegation of financial theft was reported to the home care agency and an incident report was completed.

The incident report indicated home care agency leadership received a report of financial theft that occurred when the AP worked in the client's home. The incident report indicated the client's family discovered the client's bank card missing and five fraudulent transactions on a bank statement. The incident report indicated law enforcement was notified, a police report filed, and the AP was placed on suspension for the duration of the investigation.

The home care agency's internal investigation indicated a conclusion statement written by home care agency leadership that law enforcement spoke with the home care agency, was provided documentation that an institute of higher learning had verified the AP had used the bank card for education expenses and law enforcement planned to pursue charges against the AP.

Financial records indicated fraudulent bank charges were made payable to the AP's educational institution from the client's bank account and posted to the AP's education account.

Law enforcement records indicated law enforcement was called when the client's bank card was discovered missing and five unauthorized charges totaling over ten thousand dollars were discovered on the client's bank statement. Law enforcement records indicated a home care agency was hired to provide services for the client and the AP had worked shifts in the home. Law enforcement records indicated the AP had enrolled at an educational institute and had recently paid tuition. Law enforcement records indicated the educational institution's finance department provided the investigating officer with the AP's education account and receipts for payment which confirmed the AP had used the client's bank card to pay tuition expenses. Law enforcement records indicated the first charge to the client's bank card occurred the first day the AP worked in the client's home. Law enforcement records indicated law enforcement's intent to charge the AP. Law enforcement records indicated the AP had left the area.

During an interview, licensed home care staff stated the client told her the AP had charged over ten thousand dollars to her bank card. Licensed home care staff stated she had not participated in an internal investigation and only had knowledge of what the client shared with her. Licensed home care staff stated she had not spoke with the AP, he "just disappeared" and was no longer

with the agency. Licensed home care staff stated law enforcement was involved, and home care leadership were managing the incident.

During an interview, home care leadership stated the agency was made aware of the financial theft and an investigation was initiated with law enforcement and the agency. Home care leadership stated at the time the agency was alerted to the theft incident the AP's employment had ended for other reasons. Home care leadership stated the AP went "missing in action" when the AP was notified of the investigation. Home care leadership stated the fraudulent charges were traced to the AP because the client's card was used to pay for the AP's education tuition and online items. Home care leadership stated the client's money was returned by the educational institute and the AP has been charged with financial exploitation of a vulnerable adult.

During an interview, the client stated the AP had been to her home to provide services and the AP asked uncomfortable questions the client felt were inappropriate. The client stated due to blindness she required assistance when family was unavailable. The client stated a family member reviewed bank statements and discovered the client's bank card was missing. The client stated the bank card was used to pay tuition expenses on the AP's education account and law enforcement was charging the AP. The client stated she was fearful of the AP, however, continued to employ the home care agency and had no complaints about the service provided by current agency staff.

During an interview, a family member stated the client required assistance due to blindness and the family utilized a home care agency to fill in while the family member worked. A family member stated fraudulent charges were discovered on the client's bank account when he reviewed bank statements. A family member stated an educational institution verified the client's bank card was used to apply payments exceeding ten thousand dollars to the AP's education expenses. A family member stated the home care agency was cooperative with the family and law enforcement was charging the AP. A family member stated the client continued to employ the home care agency and was happy with the current staff.

The AP did not respond to the investigator's request for an interview.

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:** Yes

**Family/Responsible Party interviewed:** Yes

**Alleged Perpetrator interviewed:** Attempted, AP's whereabouts unknown

**Action taken by facility:**

The facility conducted an internal investigation and the AP's employment was ended.

**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

St. Louis County Attorney

Duluth City Attorney

Duluth Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  H39913	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/10/2025
NAME OF PROVIDER OR SUPPLIER  CORNERSTONE CAREGIVING		STREET ADDRESS, CITY, STATE, ZIP CODE  7582 CURRELL BOULEVARD STE 111 WOODBURY, MN 55125		
(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the correction order is issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL399135504M/ #HL399132779C</p> <p>On October 10, 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 16 clients receiving services under the provider's Comprehensive Home Care License.</p> <p>The following correction order is issued for #HL399135504M/ #HL399132779C tag identification 0325.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing 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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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).</p>	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment	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	<p>Continued From page 1</p> <p>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</p> <p>This MN Requirement is not met as evidenced by: Based on interviews, and document review, the home care agency failed to ensure one of one clients reviewed (C1) was free from maltreatment.</p> <p>Findings include:</p> <p>On October 10, 2025, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that the individual staff person was responsible for the maltreatment, in connection with incidents which occurred at C1's home. The MDH concluded there was a preponderance of evidence that maltreatment occurred.</p>	0 325	No plan of correction is required for this tag.	