Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349484805M
Compliance #: HL349481011C

Date Concluded: November 20, 2025

Name, Address, and County of Licensee Investigated:
Estherra Care LLC
3257 98th Circle North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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) abused a resident when he gave her marijuana after coercing her to kiss him to ensure her secrecy. As a result, the resident became physically ill from the effects of the marijuana and required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to act in good faith and within the best interest of the resident when he gave her his vape which contained marijuana to help her sleep instead of her prescribed medications for insomnia. The resident became ill and required hospitalization. Although it could not be determined whether a kiss occurred between the AP and the resident, a kiss on the lips does not meet the definition of sexual abuse, therefore abuse was not substantiated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator toured the facility and observed staff interactions with residents, medication administration, and documentation systems.

The resident resided in an assisted living facility. The resident's diagnoses included neurocognitive disorders (effects learning and memory). The resident's service plan included assistance with medications and behavior management. The resident's nursing assessment indicated the resident was independent in her day-to-day cares. The nursing assessment indicated the resident had insomnia (difficulty sleeping).

The resident's medication administration records (MARs) indicated the resident had medication available for insomnia, however the MARs lacked indication the resident received any medication.

An incident report, completed by unlicensed personnel (ULP) #3, indicated at the start of her shift, during a safety check, the resident called out for help. The resident reported they were feeling dizzy and stated the AP had given them "weed" and they were feeling unwell. The AP was at the facility and ULP #3 called him into the resident's room. The AP denied giving the resident "weed" but stated the resident wanted to try his vape, so he gave it to them. The AP stated after using the vape he asked the resident if they were ok and gave them water. The resident vomited, but later said they were feeling better and wanted to rest. The ULP #3 documented she thought the resident was stable and did not report the incident to the manager immediately but acknowledged she should have.

Resident services notes indicated the day of the incident report, ULP #3 documented at the 2:00 p.m. end of shift report she observed the resident sleeping frequently during the shift. Staff encouraged the resident to participate in activities, but they declined stating they were tired and wanted to rest.

Hospital records indicated the resident went to the emergency room (ER) the day after using marijuana. The resident reported they were given marijuana to help sleep, but instead it made them feel high and panicky, with worries they were going to die. The hospital completed toxicology testing (testing used to determine what drugs/substances a person used). The testing confirmed the resident used marijuana. Hospital records indicated the resident reported they were sexually assaulted and given marijuana by the AP, which happened the morning prior. They reported in the morning, prior to shift change between 5:00 a.m. and 6:00 a.m., the AP came into their room, and they reported they were having a hard time sleeping. The resident stated the AP then asked what they took to sleep, and they said hydralazine, to which the AP stated he expected them to say weed. The resident stated they told the AP they do not smoke

weed; only vape. The AP then offered to give the resident weed and asked them to do something so they would not “snitch.” The resident stated they and the AP kissed on the lips. Then AP then left their room and came back with a weed vape pen that they used once. The AP told them to do it two more times, to which they did. The resident reported they began to feel their body change and could not move. They yelled for help. The AP and the morning shift staff, ULP #3, came. The resident stated the staff tried to calm them down and had them drink some water. The resident said they started throwing up, but felt better after and went to sleep.

During an interview, a manager said the AP was newly employed by the facility at the time of the incident and worked alongside ULP #2 for training during the night shift. The manager said ULP #2 left the facility before the completion of the shift because she had an emergency, so the AP was alone in the facility for approximately one hour. It was during this time when the incident occurred. The manager said she spoke to the AP about the incident, and he told her he checked on the resident during a routine safety check and found her awake. The manger said the AP told her he engaged in a conversation with the resident about “vaping” (inhaling nicotine). The AP told the manager, the resident insisted he should go and get his vape so she could use it. The manager said the AP told her he went to his car, got his vape, and gave it to the resident. The manager said the AP denied giving the resident marijuana. The manager said the AP denied kissing the resident. The manager said the AP told her he gave the resident his vape because she “insisted.” The manager said the AP was remorseful. The manager said she terminated the AP’s employment at the facility.

During an interview, ULP #2 said she worked with the AP during the shift (overnight shift), but she became ill and left the facility about an hour early, leaving the AP alone. ULP #2 said the AP was a new employee but had completed training and appeared to be doing well. ULP #2 said the resident required hourly safety checks during the night. ULP #2 said she only saw the resident once, and the AP completed the rest of the safety checks. ULP #2 said nothing seemed unusual about the resident or AP while she was at the facility.

ULP #3 did not respond to request for an interview.

During an interview, the resident said the AP checked on them and noticed they were awake. The resident said the AP asked them if they wanted to try “weed” to help them sleep. The resident said they had never used the substance, but decided to try it to see if it would help them sleep. The AP brought it to them, and they took a couple of “hits.” The resident said they got “high,” then ULP #3 came into work at the facility, so they told her what happened because they felt sick. The AP returned with ULP #3, and they helped them “come down.” The resident said the AP told them to tell people they got the weed from someone else, not him. The next day, they called a crisis worker, then went to the hospital because they did not feel safe. The resident said the AP kissed them prior to giving them “weed,” but stopped when they told him to. The resident denied further physical contact with the AP.

During an interview, the AP said he completed a safety check to the resident at the end of his shift and found them using a vape. The AP said the resident told him it was nicotine, and offered for him to use it, but he told them he did not vape. The AP said he left the resident's room. The AP said when ULP #3 arrived the resident called them because they were not feeling well. The AP said the resident wanted to go to the hospital, but then changed their mind so he left the facility. The AP said he did not touch, hug, or kiss the resident. The AP said he did not give the resident marijuana. The AP said he did not go to his car and get a vape for the resident.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Not Applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided education to staff members on reporting maltreatment. The AP no longer works for the facility.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34948	A. BUILDING: _____ B. WING _____	C 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTHERRA CARE LLC	3257 98TH CIRCLE NORTH BROOKLYN PARK, MN 55443

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, 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: HL349481011C/HL349484805M On October 28, 20025, 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 four residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for HL349481011C/HL349484805M, tag identification 1730, 2360.	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 Assisted Living Facilities. 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 144G.31 SUBDIVISION 1-3.	
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 1 (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 2 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to complete medication reconciliation for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted into the facility for diagnoses including neurocognitive disorders. R1's service plan dated September 26, 2024, indicated R1 received medication management services. R1's nursing assessment dated October 14, 2025, indicated the licensee would have a registered nurse (RN) clarify medication orders/changes and instructions from R1's medical providers.	01730		

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01730	Continued From page 3 R1's document titled, Provider Orders, dated October 23, 2025, contained a list of R1's medication. The list contained an electronic record of medications from R1's physician and signed by R1's physician on October 23, 2025. There were handwritten discontinuation dates next to various medications. This included the following medications: -Robitussin (cough suppressant): Take one or two teaspoons by mouth every four hours as needed for cough. Discontinue the medication on February 13, 2025. -Milk of Magnesia (for constipation) 15 milliliters (ml): Take 15 ml or 30 ml by mouth once a day as needed. Discontinue the medication on February 13, 2025. -Imodium (for diarrhea) 2 milligrams (mg): Take 4 mg after the first loose stool and 2 mg after each loose stool up to 16 mg per day. Discontinue the medication on February 13, 2025. -Mag Citrate Lemon Sol (for constipation): Take 148 milliliters (ml) by mouth once a day as needed. Discontinue the medication on May 5, 2025. R1's medication administration record (MAR) dated July 1, 2025, through July 31, 2025, indicated the licensee failed to discontinue these medications. The MAR contained orders for these medication for staff members to give to R1. Although there were no documented administrations, the MAR indicated these medications were active, and available to staff to administer. On October 29, 2025, at 3:12 p.m., owner (OW)-A said the licensee had two nurses who are responsible to oversee medication management, and both nurse complete	01730		

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01730	Continued From page 4 medication reconciliation. On November 3, 2025, at 11:55 a.m., RN-C said R1 managed her medical appointments independently, and the physicians sent medication orders directly to the licensee's pharmacy provider. RN-C said she was not the nurse who completed medication reconciliation. On November 4, 2025, at 3:38 p.m., RN-D said he managed resident medications, and RN-C managed nursing assessments, but sometimes their duties overlap. RN-D acknowledge there were discrepancies on the MAR, however he said he made attempts to reach R1's community physicians and was not always aware of medications changes. R1 had "my chart", but she would not allow the licensee nurses to access the documentation system. RN-D said physicians send medication orders to the licensee's pharmacy provider and they put the medication orders into the licensee's computer system, then the licensee nurse would verify the order to make it active. RN-D said R1 went to the hospital frequently, and the licensee nurses would not always know what occurred, or if there were order changes to her medications. The licensee's policy titled, Medication Management Individualized Plan, dated June 1, 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident and would complete medication reconciliation. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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02360	Continued From page 5	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was 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.	02360		