Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349485541M
Compliance #: HL349487820C

Date Concluded: January 13, 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: Brooke Anderson, RN
Special Investigator

Finding: Not Substantiated

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 facility neglected the resident when the facility failed to order labs needed for a prescription refill resulting in a hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did not receive his antipsychotic medication as ordered, there was not a preponderance of evidence to determine that neglect occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker. The investigation included review of the resident records, hospital records, facility incident reports, staff schedules, law enforcement reports, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia and post-traumatic stress disorder. The resident's service plan included assistance with medication, appointments, and behavior management. The resident's assessment indicated the resident was cognitively intact and was his own person.

Facility documents indicated the resident admitted to the facility from the hospital. The facility staff attempted to set up lab appointments, but the resident refused. Facility staff attempted to contact a medical provider, but the resident requested a new medical provider. The facility attempted to get new medical provider scheduled and during the wait, staff monitored the resident's behavior and side effects. When behaviors escalated, and the facility learned about the resident's Jarvis order (a court-ordered petition in Minnesota that allows a patient to be given antipsychotic medication without their consent), 911 was contacted and the resident was sent for evaluation.

During an interview, the facility nurse stated when the resident admitted, the facility made continuous attempts to schedule labs and order medications. When the resident became increasingly agitated, the facility reached out to a family member that informed the facility the resident was on a Jarvis order. Once the facility knew about the Jarvis order, 911 was notified. Following his hospitalization, the resident moved to a different setting.

During an interview, the case manager stated the resident refused his lab draws and deconditioned quickly leading to his hospitalization. The case manager stated she did not feel the incident was intentional.

During an interview, the resident stated the care at the facility was fine; there were just some misunderstandings.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, attempts made were not successful.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility made attempts to obtain medications and schedule the lab draws for the resident.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 12/11/2024

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 On December 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL349487820C/#HL349485541M. No correction orders are issued.	0 000		