Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370068783M
Compliance #: HL370069484C

Date Concluded: February 19, 2025

Name, Address, and County of Licensee Investigated:
Esteem Home Health Services
4024 Idaho Avenue North
Crystal, MN 55427
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 staff the facility at a level and manner to meet the care needs of the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The investigation did not reveal evidence the residents care needs were not met. During the investigation, additional allegations were made that the facility did not have the resident's medications available, did not have the equipment the resident needed for mobility, and were not meeting her needs due to the resident making 911 calls over a 10-month period. The investigation found the facility provided the care, equipment, and medications as ordered and as the resident allowed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, the resident's case manager and mental health provider. The

investigator contacted law enforcement and medical supply company. The investigation included review of the resident records, facility incident reports, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed resident care provided by staff, and staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included morbid obesity, type II diabetes, and borderline personality disorder. The resident's service plan included two-person assistance with turning and repositioning, transfers, mobility, behavior management and diabetes management. The resident's assessment indicated the resident was their own legal person, and alert with behavior concerns. The resident required the use of a Hoyer lift (a full body mechanical lift) for transfers and could not walk. The resident used an electric wheelchair independently.

During the investigation, the investigator contacted the medical equipment supply company by phone, who confirmed the Hoyer lift was delivered to the facility eight days prior to the resident's arrival to the facility.

The facility staff schedules indicated there were multiple overnight shifts with one staff member present in the facility, and a float staff who was "on call" to come to the facility if needed.

The resident's medication administration records indicated multiple incidents of the resident's refusal of blood sugar checks, insulin, and other oral medications. Pharmacy delivery records indicated the resident's medications were available and the resident was not without a supply.

The resident's service delivery records indicated cares were provided per the resident's plan of care.

Nurse's notes indicated the facility registered nurse (RN) communicated with the resident's primary care provider (PCP) regarding medical concerns, medical referrals for specialty cares, refusal of medications, medication order changes and refusal of blood sugar checks. The PCP ordered a blood sugar monitoring device for improved compliance of blood sugar checks.

Nurse's notes indicated when the resident exhibited behaviors such as refusing medications, agitation, swearing, yelling, hitting, threatening, paranoia, physical and verbal aggression. The staff completed interventions such as spending one on one time with the resident, offered food, took the resident for a walk, reapproached with as needed medications, offered alone time and called the nurse as needed.

A nurse's note indicated a meeting was held with the resident and the care team including the resident's case manager, social worker, facility nurse and licensed assisted living director (LALD) to review the residents needs and concerns with discussion of possible solutions and additional resources for the resident. The note indicated additional follow up meetings were planned and the facility assisted the resident to apply for behavioral health therapy services to learn

de-escalation skills. The facility also initiated obtaining orders for physical and occupational therapy. The facility encouraged the resident's family member to attend monthly visits to promote the mental wellbeing of the resident. Subsequent nurse's notes indicated additional care meetings included the law enforcement embedded social worker, staff from the Ombudsman's office, facility house manager, and the resident's family member. Initiation of additional interventions and services were planned.

During an interview, the law embedded mental health coordinator (MHC) stated she was referred through the police department to work with the resident due to the resident making excessive calls to 911. The MHC stated she worked with the resident towards goals, which included conversations about what is going on and getting things figured out. The MCH stated the facility was inappropriately using 911 services for transportation, so she instructed them to obtain transportation for outpatient appointments. The MHC stated the facility attempted to secure public transportation for the resident by contacting seven different transportation companies who declined to provide transportation services. The MHC stated the facility did not have a Hoyer lift for over a year after the resident was at the facility. The MHC stated the facility refused to participate in any collaboration or meetings regarding the resident.

During an interview, the resident's case manager (CM) stated when she first met the resident, she did not have a wheelchair or a Hoyer lift. The CM stated the facility completed the application to obtain mobility transportation for the resident. The CM stated she believed the facility was now meeting the needs of the resident. The CM stated the resident's attitude and outlook have completely shifted, and she seems happy.

During an interview, the LALD stated there are two staff on the day and evening shifts, and one staff plus a float staff who is on call to come in at any moment they are needed for the overnight shift. The LALD stated they have part time overnight staff and are working on getting full time overnight staff. The LALD stated they have struggled to hire staff who will stay due to the resident's behavior and treatment of staff which included verbal and physical assaults. The LALD stated they have had to hire only male staff, which they noticed helped stabilize the resident's behaviors. The LALD stated the facility had possession of a Hoyer lift and manual wheelchair prior to the resident's arrival to the facility, and the resident gets out of bed on a regular basis. The LALD stated the resident's provider sends any medication orders directly to the pharmacy, and the pharmacy delivers the medications directly to the facility. The LALD stated the medications were also on auto-refill. The LALD stated when the resident refuses medications, it is documented in the resident's record, staff attempt again later, notify the nurse, and reach out to the provider to let them know. The LALD stated they worked with the resident's medical provider to obtain a continuous glucose monitor to aide in compliance of monitoring the residents blood sugar as she frequently refused to allow staff to do a finger stick. The LALD stated the resident would call 911 as a behavior, and wanted to go to the hospital so she could have the person who supplied her with contraband meet her there. The LALD stated he believed the resident's calls to 911 have decreased due to the resident losing

contact with the person who would meet her at the hospital, and her becoming more comfortable at the facility.

During an interview, unlicensed personnel (ULP) 1 stated the Hoyer lift and wheelchair for the resident came to the facility prior to the resident's admission. ULP 1 stated the nurse went over resident medications every week to ensure all medications were available. ULP 1 stated the resident usually refused her insulin. ULP 1 stated the facility had difficulty keeping a primary care provider for the resident because she cussed them out, resulting in them dropping her as a patient, which led to difficulty at times when a prescription renewal was needed for the pharmacy. ULP 1 stated since obtaining the continuous blood sugar monitor, the resident has been compliant with blood sugar checks.

During an interview, ULP 2 stated if he needed the assistance of a second staff member on the overnight shift, he would call ULP 1 and either she or another staff member would come in to assist.

During an interview, the RN stated when he would arrive to the facility, there was always two staff members present. The RN stated the resident's medical providers send medication orders directly to the pharmacy, and he transcribes them into the medication administration record. The RN stated if medications were out, he called the pharmacy, and the medications would be delivered the same day. The RN stated when the resident refused her insulin, staff monitored her for signs and symptoms of low or high blood sugar, and he would call her medical provider.

During an interview, the resident's mental health provider (MHP) stated the resident had a history of behavior irritability, aggression, mood swings and calling 911 for non-emergent attention seeking things, related to her borderline personality disorder. MHP stated she was not aware of any concerns the resident had about her care at the facility. The MHP stated she recommended the resident to receive individual counseling, but the resident had not been interested in doing so. The MHP stated the resident sees her primary care provider regularly.

During an interview, the resident stated her needs were met at the facility and there was enough staff at the facility to help her. The resident stated she did not recall the reasons for all the calls she made to 911, and she had not called them recently. The resident stated she had no concerns about her care at the facility and felt safe at the facility. The resident denied another facility would be more appropriate for her care needs.

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 adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, resident was her own person.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility obtained medical equipment, offered and provided medications as needed, and communicated resident needs and their concerns to the medical provider.

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
	37006	A. BUILDING: _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESTEEM HOME HEALTH SERVICES	4024 IDAHO AVENUE CRYSTAL, MN 55427

(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 January 22, 2025, the Minnesota Department of Health initiated an investigation of complaint HL370069484C/HL370068783M. No correction orders are issued.	0 000		