Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL370063787M
Compliance #: HL370063667C

Date Concluded: October 16, 2026

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 staff failed to provide adequate supervision. The resident eloped from the facility, was hit by a car, and later died at the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was her own decision maker and would often leave the facility to go out into the community independently. The resident was driving her electric scooter on the street when she was struck by a car and passed away from her injuries the next day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the case manager. The investigation included review of the resident record, death record, hospital records, facility incident reports, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed care and services at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety, bipolar disorder, borderline personality disorder, history of stroke with left sided weakness, and morbid obesity. The resident's service plan included assistance with behavior management, transfers with two staff and a mechanical lift, safety checks, and wheelchair use. The resident's assessment indicated the resident was dependent on staff to perform activities of daily living and transfers, but once she was in her motorized wheelchair she could move around independently. The resident had a history of leaving the facility for a few hours at a time, but it was noted she was her own person and able to make her own decisions.

The police report indicated around 6:19 p.m., 911 was called for a car versus pedestrian accident a few blocks from the facility. When officers arrived a few minutes later, they observed the resident's electric scooter was flipped upside down and the resident appeared to suffer multiple injuries. The street was covered with snow and the sun had set. The resident did not have any lights or reflectors on her electronic scooter. The driver who struck the resident was cited for driving after his license was cancelled. The resident was taken to the emergency room for further evaluation.

Hospital records indicated the resident refused most diagnostic work and treatment. The resident passed away the next day at the hospital.

The death record indicated the resident's cause of death was complications of blunt force injuries due to a pedestrian/car collision.

During an interview, management stated the resident often went out in the community on her motorized scooter and staff knew when she left as she required assistance to get out of the house. Management stated on the evening of her accident, staff advised the resident not to go out because it was dark and snowy but the resident refused and wanted to go out anyways.

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: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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

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 10/05/2026

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 ******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: #HL370063787M/#HL370063667C On October 5, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there was one resident receiving services under the provider's Assisted Living license. The following correction order is issued for #HL370063787M/#HL370063667C, tag identification 0620.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.	0 620		

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0 620	Continued From page 2 (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R1) who died after being struck by a vehicle outside of the facility. 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's diagnoses included anxiety disorder, bipolar	0 620		

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0 620	Continued From page 3 disorder, borderline personality disorder, history of stroke with left sided hemiplegia, and morbid obesity. R1's assessment dated November 5, 2026, indicated R1 used a motorized scooter for mobility. R1 had a history of leaving the facility and not returning for hours but it was noted she was her own guardian and had the mental capacity to make self-decisions. The police report indicated on January 5, 2026, around 6:23 p.m., officers responded to a car versus pedestrian accident a few blocks from the facility. R1's scooter was flipped upside down and R1 appeared to have multiple injuries. R1 was taken to the hospital for evaluation. R1's progress notes did not detail the accident or what happened, only that on January 6, 2026, R1 was in the intensive care unit. The facility was coordinating with the hospital for R1 to return to the facility. R1 died on January 6, 2026 at the hospital. R1's death record indicated the cause of death was complications of blunt force injuries due to a pedestrian/car collision. On October 15, 2026, at 9:40 a.m., licensed assisted living director/owner (LALD/O)-A stated he was not sure if a MAARC report was done as it was an accident and the resident was taken to the hospital so it wasn't anything that was abuse. LALD/O-A stated they did an internal investigation and he would provide documentation of the investigation. The licensee's Reporting Maltreatment of Vulnerable Adult policy indicated all facility staff	0 620		

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0 620	Continued From page 4 were mandated to report maltreatment to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		