Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333582160M
Compliance #: HL333581180C

Date Concluded: July 24, 2024

Name, Address, and County of Licensee Investigated:
Amira Choice Minnetonka
2004 Plymouth Road
Minnetonka, MN 55305
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Lena Gangestad, 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 alleged perpetrators (AP) #1 and AP #2, both unlicensed caregivers, neglected the resident by marking services as completed when they were not performed. The resident was not checked on from 7:30 pm to 12:30 am. She was found on the floor with a deep cut above her left eye.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility scheduled a safety check at 7:30 PM with the next one scheduled at 1:00 AM. It may have been true no one checked on the resident after 7:30 PM until after midnight but the facility did not have any safety checks scheduled at that time during that shift.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, internal

investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living memory care unit. The resident's assessment indicated the resident needed assist of one person for mobility and alert to self only. The resident's service plan included safety checks.

An incident report indicated the resident was found on the floor shortly after midnight when AP #2 entered the room to perform a safety check. AP #2 contacted the on-call nurse, and the resident was sent to the hospital to treatment of a deep cut above her left eye.

Later a concern arose that the resident's safety checks were not performed the evening leading up to the resident's fall. A video recording was reported to the facility which showed no one entered the resident's room from 7:30 PM on the 14th day of that month until 1230 AM on the 15th (evening into night shift).

During this time, AP#1 worked the evening shift while AP #2 worked the night shift and they had documented completion of all the scheduled safety checks from 7:30 PM to 12:30 AM.

The service checkoff list for the 14th indicated the facility scheduled safety checks at 7:00 PM and at 7:30 PM on the evening shift. The same document indicated the next safety check the facility scheduled was at 1:00 AM on the night shift. A review of this document identified no scheduled safety checks between 7:30 PM and 1:00 AM for AP #1 nor AP #2 to perform.

The same document indicated the facility did add more safety checks like one at 11 PM but that did not go into effect until the 15th (about 24 hours after the resident's fall).

During an interview, a manager stated she received a report from triage about the fall overnight. The manager stated the resident returned to the facility the same day with an order for wound care. The manager said that staff members were expected to perform safety checks on all residents in the memory care unit every two hours. However, according to the video footage provided by the family in the resident's room, staff members did not check on the resident from 7:30 pm to 12:30 am, when the resident was found on the floor.

During an interview, AP #1 stated she had already left for the day when the resident was found on the floor. She was not sure, but she said the last time she checked on the resident was around 8 pm. AP #1 stated she recalled the resident safety checks were about every three hours.

During an interview, AP #2 stated she found the resident on the floor during her rounds. She stated she recalled the resident's safety checks were about every two hours.

During the investigation, despite multiple attempts, the investigator was unable to obtain a copy of the video footage, so it was not viewed.

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. The resident was deceased.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The resident was sent to the hospital for further evaluation. The resident’s service plan was updated with additional safety checks.

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
	33358	A. BUILDING: _____ B. WING _____	C 06/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE MINNETONKA	2004 PLYMOUTH ROAD MINNETONKA, MN 55305

(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 June 24, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL333582160M/HL333581180C, and #HL333584081M/HL333584687C . No correction orders are issued.	0 000		