Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333584081M
Compliance #: HL333584687C

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 facility neglected the resident when he was found on the toilet and unable to bear weight. The resident was sent to the hospital and diagnosed with a right hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had a fracture hip, the facility performed safety checks as planned and provided appropriate care when the resident was found in pain.

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, staff schedules, policies, and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included bradycardia, anxiety, and major depression disorder. The resident's service plan included

routine safety check at 1am, 3am, 5am, 8am, 10am, 12pm, 2pm, 4pm, 6pm, 8pm, 10pm. The resident's assessment indicated that the resident was a wander, walking around independently and did not use any mobility devices.

An incident report indicated caregivers found the resident in the bathroom at approximately 9:45 a.m. one morning and could not stand up. The same document indicated the resident was not able to say what happened. The caregivers assisted the resident back to bed, but he was guarding his hip and in a lot of pain. The facility called 911 and sent the resident to the hospital.

The service checkoff list indicated the resident had a routine safety check scheduled at 10 a.m.

During an interview, the manager stated the staff members notified her about the incident on the same morning. She said the resident was walking independently. She was not sure what happened, but staff checked on him routinely per care plan.

During an interview, the staff member stated the resident walked independently and steady on his feet. She said staff checked on the resident very two hours.

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: Not Applicable.

Action taken by facility:
The staff members followed plan of care. The resident was sent to the hospital for further evaluation in a timely manner.

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		