Electronically Delivered

February 3, 2026

Licensee
Amira Choice Minnetonka
2004 Plymouth Road
Minnetonka, MN 55305

RE: Project Number(s) SL33358016

Dear Licensee:

On January 27, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on November 5, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

Electronically Delivered

November 17, 2025

Licensee
Amira Choice Minnetonka
2004 Plymouth Road
Minnetonka, MN 55305

RE: Project Number(s) SL33358016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

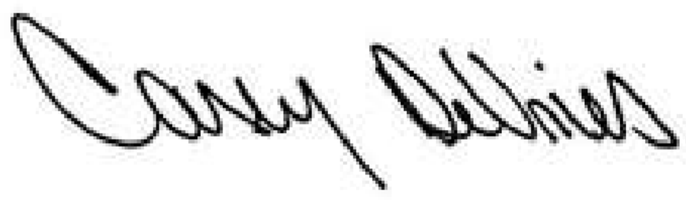
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

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 _____	11/05/2025

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 *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33358016-0 On November 3, 2025, through November 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 109 residents; 57 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on November 4, 2025, issued for SL33358016-0, tag identification 1950. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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.	

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0 510	Continued From page 1	0 510		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving for one of six employees (unlicensed personnel (ULP)-B). In addition, the licensee failed to follow their policy related to personal protective equipment (PPE) during eye drop administration for two of three employees (ULP-Q, ULP-R). 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 510		

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0 510	Continued From page 2 found to be pervasive). The findings include: GLOVES ULP-B was hired on August 25, 2025, to provide assisted living services. On November 4, 2025, at approximately 7:40 a.m., the surveyor observed ULP-B apply gloves, assist R4 with removal and application of shirt, set up wash cloth and toothbrush, and remove gloves. Without performing hand hygiene, ULP-B applied a new pair of gloves, made R4's bed, moved R4's wheelchair to bathroom sink, cued and assisted R4 with oral care, cleaned R4's face with washcloth, placed glasses on R4, placed footrests on R4's wheelchair, placed R4's brace onto the right leg, retrieved a trash bin liner, picked up soiled incontinent products from the bin that did not contain a trash liner and placed in the new liner into the trash bin, and removed gloves. Without performing hand hygiene, ULP-B closed multiple doors and turned off the lights in R4's room, exited R4's room, brought trash to the trash room, and then washed their hands in the dining room. On November 5, 2025, at 12:11 a.m., clinical nurse supervisor (CNS)-C stated ULP were trained to perform hand hygiene after glove removal. The Centers for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended to clean your hands: - immediately before touching a patient; - before performing an aseptic task such as	0 510		

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0 510	Continued From page 3 placing and indwelling device or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or patient's surroundings; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. The licensee's Standard Infection Control Precautions policy dated August 1, 2022, read, "Wash hands after removing gloves." EYE DROPS ULP-Q was hired on October 3, 2022, to provide assisted living services. ULP-R was hired on July 1, 2024, to provide assisted living services. On November 4, 2025, at 6:27 a.m., the surveyor observed ULP-Q administer eye drops to R11 without wearing gloves. On November 4, 2025, at 6:53a.m., the surveyor observed ULP-Q administer eye drops to R8 without wearing gloves. On November 4, 2025, at 7:24 a.m., the surveyor observed ULP-R administer eye drops to R10 without wearing gloves. On November 4, 2025, at 7:14 a.m., the surveyor inquired to ULP-Q if they were trained to wear gloves with eye drop administration. ULP-Q stated, "no, not really." On November 4, 2025, at 7:38 a.m., the surveyor	0 510		

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0 510	Continued From page 4 inquired to ULP-R if they were trained to wear gloves during eye drop administration. ULP-R stated, "not really." ULP-R stated it was a preference to wear gloves and some ULP wore gloves, and some did not during eye drop administration. On November 5, 2025, at 12:11 a.m., CNS-C stated ULP were trained to wear gloves when administering eye drops. The licensee's Medication Administration: Eye Drops policy dated February 2, 2025, indicated gloves were to be worn when administering eye drops. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	0 630		

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0 630	Continued From page 5 Based on interview and record review the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of five residents (R2). 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: R2 admitted to the licensee on June 11, 2025, and began receiving assisted living services. R2's Service Plan Agreement signed July 13, 2025, indicated R2 received assistance with mechanical lift transfers, blood glucose monitoring, dressing, activities, escorts, bathing, grooming, nail care, oral care, mobility, medication administration, and toileting. R2's Comprehensive Assessment/Licensed Services dated October 30, 2025, included a section titled Vulnerabilities and Abuse Prevention. The section indicated R2 was at risk to be abused and was not at risk to abuse other vulnerable adults. Section 1.a.1 indicated no known abuse or neglect at this time to R2. The assessment lacked statement of the specific measures to be taken to minimize the risk of abuse to R2.	0 630		

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0 630	Continued From page 6 On November 5, 2025, at 12:37 p.m., during interview with clinical nurse supervisor (CNS)-C and regional clinical director (RCD)-S, CNS-C stated they updated all residents IAPPs who were in the secured unit after another resident who resided in the unit, was pushing other residents. RCD-S and CNS-C acknowledged R2's IAPP lacked specific measures taken to minimize the risk of abuse to R2. RCD-S stated statements were built into the assessments for the nurse to click on when assessments were completed. RCD-S stated statements would be listed under 1.a.1 for R2 however, the statements were not selected in the assessment. The licensee's Assessment of Clients-Initial and Ongoing dated May 23, 2022, indicated the comprehensive assessment would include the resident's area of vulnerability and susceptibility to maltreatment and weather the resident poses a risk to other vulnerable adults. The registered nurse (RN) would use the assessment as the basis for the resident individual abuse prevention plan that identified the specific measures to be taken to minimize the risk of maltreatment to the resident or other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse	01730		

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01730	Continued From page 7 must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

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01730	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a current individualized medication management record for each resident to include all required content for one of five residents (R4). 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: R4 admitted to the licensee on October 6, 2023, and began receiving assisted living services. R4's diagnoses included dementia, fracture of lower end of the right femur, closed fracture of distal end of the right femur with delayed healing, presence of right artificial knee joint, and physical deconditioning. R4's Service Plan Agreement signed September 27, 2025, indicated R4 received assistance with medication administration, escorts, activities, bathing, behavior management, meals, placement and cleaning of glasses, brace assistance, compression stockings, dressing, nail care, oral care, grooming, vital sign monitoring, laundry, housekeeping, bed mobility, mobility,	01730		

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01730	Continued From page 9 transfers with mechanical lift, and toileting. R4's prescriber's orders dated September 8, 2025, included hydrocortisone cream 2.5 percent (%) twice per day as needed (PRN). R4's Medication Sheet dated November 1, 2025, through November 30, 2025, included hydrocortisone cream 2.5 % apply to affected area topically two times daily PRN for rash. Nurse notified via medication dashboard after administration. Staff to call nurse if ineffective. The medication administration record (MAR) lacked the location of where to apply the cream. The licensee's Basic Assessment/ULP Services dated October 2, 2025, indicated the following: - medication were administered by unlicensed personnel (ULP); - R4 did not require special medication preparation; - ULP assisted with oral medication and eye drops; and - R4 did not have topical medications. R4's Comprehensive Assessment/Licensed Services dated October 2, 2025, indicated the following: - medications were kept in a locked medication cart; and - licensed employees were responsible for medication oversite, supply management, PRN medication review, and new order processing. R4's medication management plan comprised of multiple documents lacked documentation of specific resident instructions related to medication administration. In addition, the medication management plan was not accurate	01730		

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01730	Continued From page 10 as it indicated R4 did not have topical medications. On November 5, 2025, at 12:24 p.m., the surveyor inquired where R4's hydrocortisone cream was applied. Clinical nurse supervisor (CNS)-C stated, "I can assume where it is applied but that does not prove anything." CNS-C stated special instructions should have been added to the instruction column in the electronic medication administration record (EMAR). CNS-C stated instructions for medications were normally added when the medication order was processed. The licensee's Medication and Treatment Implementation policy dated August 1, 2021, indicated when adding a new order or prescription to the resident record the registered nurses (RN) must take action to implement the order. The actions included: - adding the order or prescription to the resident record in the appropriate place and updating the service plan, care plan, medication record/ MAR or other documents as necessary to reflect any changes in prescription or orders; - include in the resident record written instructions for staff to follow when implementing the new order or prescription. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01950 SS=I	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies	01950		

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(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
01950	Continued From page 11 must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to train two of two unlicensed personnel ((ULP)-B, ULP-G) in the proper methods for a resident (R4) receiving treatment services prior to delegating nursing tasks of prescribed treatments, nor did the licensee ensure the ULP demonstrated to the registered nurse (RN), the ability to competently follow the procedure, which lead to a treatment error. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01950		

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 _____	11/05/2025

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01950	Continued From page 12 a large portion or all of the residents). The findings include: R4 admitted to the licensee on October 6, 2023, and began receiving assisted living services. R4's diagnoses included dementia, fracture of lower end of the right femur, closed fracture of distal end of the right femur with delayed healing, presence of right artificial knee joint, and physical deconditioning. R4's Service Plan Agreement signed September 27, 2025, indicated R4 received assistance with medication administration, escorts, activities, bathing, behavior management, meals, placement and cleaning of glasses, brace assistance, compression stockings, dressing, nail care, oral care, grooming, vital sign monitoring, laundry, housekeeping, bed mobility, mobility, transfers with mechanical lift, and toileting. The service plan indicated the leg brace needed to be on at all times. ULP were to assist R4 with the brace and were to report to nurse with any concerns of skin breakdown, complaints of pain or discomfort with use of brace, ill-fitting brace, or malfunctioning of the brace. R4's providers orders signed September 8, 2025, included the following: - "musculoskeletal condition or presence of cast/brace which prevents 90 degree flexion." - weight bearing restriction, no right knee range of motion; - weight bearing as tolerated in knee immobilizer; and - "knee immobilizer to the right lower extremity. Remove 3 times daily and as needed to check	01950		

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01950	Continued From page 13 skin integrity. OK to remove for hygiene and dressing changes if needed. No knee range of motion at ANY time." R4's Service Checkoff List dated October 2025, indicated brace assistance was completed on every a.m., p.m., and overnight shift from October 1, 2025, through October 31, 2025. It indicated 20 different employees provided brace assistance in the month of October. R4's service Checkoff List dated November 2025, indicated brace assistance was completed on every a.m., p.m., and overnight shift from November 1, 2025, through November 3, 2025. In addition, it indicated five different employees provided brace assistance in the month of November. In total, the Service Checkoff Lists dated between October 1, 2025, and November 3, 2025, indicated 20 employees had provided R4 with brace assistance. Two of the twenty employees, ULP-K and ULP-L, signed a document titled Daily Nurse to Care Staff Communication Report dated September 29, 2025. On November 4, 2025, at approximately 7:40 a.m., during cares, the surveyor observed ULP-B and ULP-G with R4 sitting in their wheelchair. ULP-B started to apply a Bird & Cronin knee immobilizer (brace) with the wider side of the brace facing the ankle. ULP-G began assisting ULP-B by strapping the straps of the brace. The surveyor observed the device sitting at the ankle and extending to mid knee. ULP-B was hired on August 25, 2025, to provide assisted living services.	01950		

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01950	Continued From page 14 ULP-G was hired on October 13, 2025, to provide assisted living services. ULP-B and ULP-G's records lacked a competency evaluation on braces (immobilizers). On November 4, 2025, at 8:08 a.m., ULP-G stated they were unable to show the surveyor instructions for R4's brace because they were not assigned to R4 for cares, and they were just assisting ULP-B. On November 4, 2025, at 8:12 a.m., the surveyor observed instructions available to the ULP regarding application of the immobilizer. The instructions indicated R4 was able to bear weight as tolerated with brace in place, ULP were to report any concerns of skin breakdown, pain, ill-fitting brace, or malfunctioning brace to the nurse. ULP-B stated, "I can't remember who trained me, but they showed me at night that was why I was struggling to put it on. I know they said to put on and make the straps go on every which way." ULP-B stated another ULP trained them on how to apply R4's brace. On November 4, 2025, at 8:15 a.m., CNS-C stated R4's brace was on 24 hours per day except for short periods of time and then it was reapplied. CNS-C stated the wide side of the brace was to be applied at the top of the leg. The surveyor requested documents for R4, and training documents related to the brace. In addition, the surveyor told CNS-C they believed the brace was applied incorrectly during the morning observation. On November 4, 2025, at 8:36 a.m., CNS-C	01950		

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01950	Continued From page 15 stated they did not complete a brace application competency evaluation with any ULP. CNS-C stated, "In hindsight, I should have. We were just talking about that in stand up. I did show some aides how to apply." The surveyor inquired how many staff members they trained on the brace. CNS-C stated, "five or six" and they would let the surveyor know when they found the book that had the documentation of the training held. On November 4, 2025, at 8:49 a.m., CNS-C provided the surveyor with a document titled Daily Nurse to Care Staff Communication Report dated September 29, 2025, and stated the ULP who received brace training for R4 signed the back of the page. The surveyor observed five ULP attended the meeting (ULP-K, ULP-L, ULP-M, ULP-N, ULP-O). CNS-C stated the meetings were pre-typed and the document did not include any content for the training provided on R4. CNS-C stated they did not put an addendum to the meeting and "sometimes things get away from you and they shouldn't." On November 4, 2025, at 10:00 a.m., the surveyor observed R4's brace still applied incorrectly with the wide side of the brace to the ankle and the brace being placed at the ankle to the mid knee. ULP-B was in the room with contracted therapy assistant and assisted to transfer R4 to the wheelchair. Prior to the transfer, the surveyor observed R4 sitting at the edge of the bed with the knee approximately at a 90-degree angle. During the transfer R4 called out and was grimacing. The surveyor had ULP-B remove the brace in order to obtain the brand of the brace. ULP-B then tried to reapply the brace to R4. The surveyor intervened and told them to contact a nurse for assistance as the brace was	01950		

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01950	Continued From page 16 being applied incorrectly. On November 4, 2025, at 10:16 a.m., CNS-C stated they had not been back to look at R4's brace. CNS-C pointed to the areas on the body to wear the brace should be applied and pointed to mid-thigh to mid-calf region. CNS-C stated no ULP contacted them on how to apply brace correctly today, however, they may have contacted a different nurse. On November 4, 2025, from 11:12 a.m., the surveyor attempted to call ULP-K. On November 4, 2025, at 11:15 a.m., the surveyor attempted to call ULP-L. ULP-L called the surveyor two times at 11:34 a.m., and 11:43 a.m., while the surveyor was on the other line. The surveyor attempted to recontact ULP-L without success. On November 4, 2025, at 11:17 a.m., ULP-M stated they had not provided cares to R4. ULP-M stated they did not specifically remember being trained on R4's brace. On November 4, 2025, at 11:21 a.m., the surveyor attempted to call ULP-N. On November 4, 2025, at 11:24 a.m., ULP-O stated they remember being trained by a nurse for brace application on a different (male) resident with a different brace. ULP-O stated they were trained by two different ULP on how to apply R4's brace. ULP-O stated the brace should be applied just above the ankle to the knee. On November 4, 2025, at 11:40 a.m., the surveyor attempted to contact R4's primary	01950		

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01950	Continued From page 17 provider related to brace application and potential adverse reactions from wearing brace improperly. On November 11, 2025, at 11:55 a.m., contract physical therapist (CPT)-P stated R4 should only bear weight to their right leg with the immobilizer on. CPT-P stated R4 should not complete range of motion (ROM) to their right leg and should keep right leg straight at all times. CPT-P stated they did not know if there would be an adverse reaction if the brace was not applied correctly and the surveyor should contact the surgeon. CPT-P stated they just follow the prescriber's orders. On November 4, 2025, at 11:59 a.m., the surveyor attempted to contact R4's orthopedic provider related to brace application and potential adverse reactions from wearing brace improperly. The undated manufacturer's instructions for Bird & Cronin Knee immobilizer indicated the brace length should be measured to fit the leg two to three inches above the lateral malleolus (ankle) and six to eight inches below the femoral head (hip). In addition, the affected leg should be in full extension when brace is placed. The licensee's delegation of Nursing Services-Treatments effective date March 1, 2014, indicated a registered nurse (RN) may delegate treatments to ULP that: - have successfully completed the training required for ULP; - have been trained in the service to be provided; and - have demonstrated to the RN the ability to	01950		

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01950	Continued From page 18 competently follow the procedures for the residents and possess the knowledge and skills consistent with the complexity of the tasks. In addition, prior to delegation the RN must develop written specific instructions for each resident and document those instructions in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01950		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

AMIRA CHOICE MINNETONKA
2004 PLYMOUTH ROAD
Minnetonka, MN 55305
Hennepin County
Parcel:

Phone:

License Info

License: HFID 33358

Risk:
License:
Expires on:
CFPM: Chase Crowley
CFPM #: 9638; Exp: 8/11/2028

Inspection Info

Report Number: F8041251153
Inspection Type: Full - Single
Date: 11/3/2025 Time: 11:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Inspection was completed with the Culinary Director, Chase Crowley. Ashley Crews was the lead Health Regulation Division Nurse Evaluator on site completing site survey.

Establishment has a kitchen, bistro and memory care on the main floor. Food that is brought to memory care is plated in the main kitchen. Only pastries are currently served in the bistro area.

Discussed the following:
- Employee illness policy and logging requirements
- Reportable diseases
-Reporting foodborne illness complaints to the health department
- Cooling and reheating methods
- Glove-use and bare hand contact
- Thermometer use and temperature logs
- Vomit clean-up procedures
- Highly susceptible population restrictions

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F8041251153 from 11/3/2025

Chase Crowley
Culinary Director

Sarah Conboy,
Public Health Sanitarian Supervisor
651-201-3984
sarah.conboy@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

AMIRA CHOICE MINNETONKA
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F8041251153
Inspection Type: Full
Date: 11/3/2025
Time: 11:30 AM

Food Temperature: Product/Item/Unit: sweet potato soup**; Temperature Process:** Hot-Holding
Location: soup well at 157 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: beef stew**; Temperature Process:** Cold-Holding
Location: walk-in cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: cut melon**; Temperature Process:** Cold-Holding
Location: walk-in cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: cooked potato**; Temperature Process:** Cold-Holding
Location: walk-in cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: tuna**; Temperature Process:** Cold-Holding
Location: upright cooler/cookline at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: chicken**; Temperature Process:** Cold-Holding
Location: prep cooler/cookline at 33 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: sliced tomato**; Temperature Process:** Cold-Holding
Location: prep cooler/cookline at 33 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

AMIRA CHOICE MINNETONKA
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F8041251153
Inspection Type: Full
Date: 11/3/2025
Time: 11:30 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 162 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Prep Area **Equal To** 200 PPM
Comment:
Violation Issued?: No