Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302847582M
Compliance #: HL302843040C

Date Concluded: April 11, 2025

Name, Address, and County of Licensee Investigated:
Amira Choice Champlin
119 East Hayden Lake Road
Champlin, MN 55316
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 she fell forward during a transfer from a recliner to her wheelchair, resulting in fractures in both upper arms and subsequent surgical intervention.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While an unlicensed caregiver assisted the resident transfer, the resident did fall and sustain fractures. However, while it was true the wheelchair was not locked, a video recording shows the resident sit in the wheelchair but then partially stand and fall forward when an unlocked four-wheeled walker rolled forward. Unfortunately, the resident did sustain fractures, however the facility sought medical attention after the fall occurred appropriately. It was possible the resident sustained the right arm fracture when the caregiver reached out to her as she fell forward, however this injury would be accidental.

The investigator conducted interviews with family members. 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 facility. The resident's diagnoses Bell's palsy and repeated falls. The resident's service plan included assist of one-person assist with transfers and a walker. The resident used supplemental oxygen.

One day an unlicensed caregiver was assisting a resident transfer from a chair to a wheelchair when she fell to the floor and sustained fractures.

The facility's internal investigation indicated the unlicensed caregiver was assisting the resident in transferring from a recliner to a wheelchair. The caregiver put a gait belt and helped the resident stand and pivot using her walker before allowing her to sit in the wheelchair. The resident then attempted to scoot herself back using the walker; however, the walker's brakes were not engaged, causing it to slide forward. The unlicensed caregiver attempted to pull the resident back into a seated position but was unsuccessful. The resident broke her fall with her arms.

A recording device placed in the resident's room captured a video of what occurred and was reviewed.

- The video opens with the resident arising from a power-lift recliner tipped forward. The video shows an unlicensed caregiver standing on the left side of the resident with her right hand on a transfer belt guiding the resident. The caregiver had positioned the wheelchair at a right angle and stood between the recliner and the wheelchair.
- The video continues with the resident moving forward using a four-wheeled walker and pivot to sit in the wheelchair. Meanwhile, with her right hand still on the transfer belt, the caregiver used her left hand to position the wheelchair behind the resident. As the resident lowered herself on to the seat of the wheelchair, the caregiver removed her hand from the transfer belt and used it to position the resident oxygen tubing, while continuing to hold the wheelchair in place with her left hand.
- At this moment, the video showed, the resident lifted herself off the seat of the wheelchair while her four-wheel walker rolled forward, and her upper body tipper forward as she fell to the floor initially on to her knees face forward and towards the floor. The resident's impact on the floor was out of view of the video.
- As the resident began to fall forward, the caregiver attempted to stop her and hung on to the transfer belt but was stepped and/or pulled forward with the resident. As the resident fell further, the caregiver released the resident's arm and held onto her shoulder in an attempt to lift her back into the wheelchair but was unable to do so. She then lowered the resident to the floor. At this point, the resident was positioned between the power recliner, the wheelchair, and the walker. The wheelchair had remained in place until the caregiver let go to catch the resident.

- The video continued with the caregiver stepping forward to move the four-wheel walker out of the way and attempted help the resident reposition herself on the ground by grasping resident's right wrist to turn her onto her back. The resident cried out, "Ouch, my arm." The caregiver let go of the wrist and instead held her upper arm to roll her onto her left side.

After the fall, the caregiver called her supervisor, the resident's family, and 911. The medical records indicated the resident was hospitalized and underwent surgery for a torn ligament and a right distal humerus fracture. She had pre-existing injuries with hardware in her left arm, and now had similar trauma on both sides.

During an interview, a family member stated she was not present when the fall occurred but had had watched the video. The family member stated the caregiver put a gait belt, placed the walker in front of the resident, and brought the wheelchair behind her without locking the brakes. The family member stated the caregiver held the gait belt incorrectly: from the side rather than from behind. The resident stood, turned, and began to sit while the caregiver pulled the wheelchair closer. The resident at the edge of the wheelchair, still holding the walker, and tried to scoot back into the wheelchair. The family member stated because the brakes were not locked, the wheelchair moved, causing her to fall forward. The family member stated the caregiver failed to control the resident's descent with the gait belt and pulled on her right arm, which had prior fractures and limited mobility due to a frozen shoulder. The caregiver pulled resident's arm back, let go, and the resident fell to her left, catching herself with her left arm and knee.

During the investigation, the investigator attempts to reach the unlicensed caregiver were unsuccessful.

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 in the nursing home.
Family/Responsible Party interviewed: Yes.

Action taken by facility: The facility initiated an internal investigation, reported the incident to Minnesota Adult Abuse Reporting Center and reviewed proper transfer techniques with the unlicensed caregiver.

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
	30284	A. BUILDING: _____ B. WING _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE CHAMPLIN	119 EAST HAYDEN LAKE ROAD CHAMPLIN, MN 55316

(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 March 17, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL302847582M/HL302843040C. No correction orders are issued.	0 000		