

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL333585761M  
**Compliance #:** HL333587972C

**Date Concluded:** December 31, 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:** Danyell Eccleston, RN  
Special Investigator

**Finding:** Substantiated, individual responsibility

### **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 perpetrator (AP), facility staff, neglected the resident when the AP failed to provide services to the resident per the resident's plan of care. The resident fell and laid on the floor with a broken hip yelling for help for 48 minutes before staff found her.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to assist the resident with dressing in appropriate sleep wear, perform safety checks, provide toileting assistance, and administer medication for sleeplessness. The AP failed to provide cares for approximately 9 hours prior to the resident falling. After the resident fell, she laid on the floor yelling for help for approximately 48 minutes until staff entered the apartment. The resident was sent to the hospital, diagnosed with a right hip fracture, underwent surgery for comfort, and died five days later. The resident's death record indicated the resident died of complications of a right leg fracture due to a fall five days previously.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff members providing care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, painful joint disease (osteoarthritis), and difficulty sleeping (insomnia). The resident's service plan included evening assistance dressing and getting ready for bed and directed staff to ensure the resident wore a night shirt. The service plan directed staff to complete safety checks to monitor for wandering twice during the night shift with notation staff administer trazadone, (medication used for sleep) if the resident was not sleeping by 11:00 P.M. The resident's service plan included toileting and continence care twice each night shift, indicating again the resident should wear a night shirt. The resident's assessment indicated the resident had cognitive deficits, delayed response, needed additional time for communication, had chronic knee pain, required verbal cueing, and needed assistance of one staff member for dressing and toileting and incontinence care.

During the night of the incident, the AP documented completing evening dressing assistance and two-night shift safety checks. Service checkoff documentation indicated the AP did not complete toileting twice during the night due and wrote, "other" and resident "performed self care."

Medication administration record the night of the incident indicated as needed trazadone for sleeplessness after 11:00 P.M. was not administered.

Review of video footage from the night of the incident the AP was observed opening the resident's closet full of clothing and then he went to a dresser and pulled out a long robe. The AP did not greet the resident or explain what he was about to do, rather the AP verbalized abrupt commands to the resident. The AP dressed the resident in a long open robe leaving her breasts exposed. The AP stated, "okay, go to bed", picked up items from the floor, turned off the main light, and left the resident's apartment while the resident continued to try to get comfortable and get her legs into bed. Video footage indicated the resident was up and walking in her apartment throughout the night until she lost her balance while attempting to dress herself. The resident laid on the floor yelling for help for approximately 48 minutes until staff entered the apartment. Video footage indicated staff did not enter the resident's apartment after the AP assisted with bedtime cares until over nine hours later when staff found the resident on the floor. Video footage indicated the resident expressed to emergency response team members she was in severe pain and emergency response staff removed the resident from her apartment via gurney.

Review of hospital records indicated the resident presented with a right hip fracture, underwent surgery for comfort, and died five days later.

During interview, an unlicensed staff member working the night of the incident stated she and a second staff member heard a repeating cry. The first and second staff member found the resident on the floor of her apartment.

During interview, a second unlicensed staff member working the night of the incident stated staff were directed to check on residents, especially during the night, to make sure residents are not soiled and to assist with toileting.

During interview, the AP stated he cared for the resident the evening and night shift of the incident. The AP stated he put the resident in a robe because he could not find other bed clothing for the resident. The AP stated during a night shift (which is eight hours long) he checked on residents every two hours and looked in on residents from apartment doorways. The AP stated he did not wake residents if they were sleeping in bed. The AP stated during the night he checked on the resident two times and the resident was in bed the last time he checked.

During interview, a leadership member indicated she reviewed hallway surveillance footage from the night of the incident and no staff were observed going into the resident's room, indicating safety checks and toileting were not completed. The leadership member stated the AP was assigned to the resident during the night of the incident and erroneously documented completing services. The leadership member stated the AP previously had issues conducting cares, including not performing services as indicated.

During interview, a second leadership member indicated she reviewed apartment video footage from the time in question. The second leadership member stated she had concerns regarding the care the resident received during the night of the incident, including the AP dressing the resident in a robe because the resident was likely uncomfortable. The AP failed to conduct safety checks and the resident laid on the floor for a significant amount of time after the fall. The second leadership member stated staff are to check on residents at night to make sure residents are safe and that residents are toileted as needed.

Review of the AP's employee file indicated the AP completed training regarding dementia, resident bill of rights, customer service, fall prevention, bathing and dressing, toileting, medication management, and vulnerable adults.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

**Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.**

“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

**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:** Yes.

**Action taken by facility:**

The facility conducted an internal review of the incident and re-educated staff members regarding resident safety checks. The AP is no longer employed by the facility.

**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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Hennepin County Attorney

Minnetonka City Attorney

Minnetonka Police Department



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>33358</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/07/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AMIRA CHOICE MINNETONKA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2004 PLYMOUTH ROAD MINNETONKA, MN 55305</b>
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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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL333587972C/#HL333585761M</p> <p>On November 7, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 111 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL333587972C/#HL333585761M, tag identification 2160, 2360.</p>	0 000		
02160 SS=D	<p>144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA</p> <p>(a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services:</p>	02160		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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02160	<p>Continued From page 1</p> <p>(1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities;</p> <p>(2) nonpharmacological practices that are person-centered and evidence-informed;</p> <p>(3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and</p> <p>(4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident dignity and choices for meaningful engagement with other facility residents for one of one residents (R1) who resided in the Assisted Living Dementia Care unit. The licensee failed to provide person-centered care that promoted resident dignity after the resident fell on the floor and broke her hip.</p> <p>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</p>	02160		

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02160	<p>Continued From page 2</p> <p>a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>R1's diagnoses included dementia, osteoarthritis, and insomnia.</p> <p>R1's service plan, dated 8/31/2024, indicated staff were to assist the resident with dressing, safety checks, cueing and standby assist.</p> <p>Video footage from inside R1's apartment dated 9/3/2024 indicated R1 attempted to get dressed and had her breasts exposed when she fell at 4:35 A.M. Staff members, including unlicensed personnel (ULP)-A, ULP-B, and ULP-C entered R1's apartment around 5:24 A.M. and no staff covered R1 until 5:28 A.M., 4 minutes later. ULP-A, ULP-B, and ULP-C were in the resident's apartment until fire department staff arrive at 5:44 A.M. During the timeframe ULP-A, ULP-B, and ULP-C were observed stepping over the area where R1 was laying in the floor without talking to R1, not explaining what was happening to R1, or comforting R1.</p> <p>During interview on November 7, 2024 at 12:01 P.M., a leadership member (LM)-D stated she reviewed video footage of the incident in R1's apartment and had concerns regarding the care R1 received during the time in question.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Fourteen (14) days</p>	02160		
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	<p>Continued From page 3</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility.</p> <p>Please refer to the public maltreatment report for details.</p>	02360		