Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368998282M
Compliance #: HL368999644C

Date Concluded: May 4, 2026

Name, Address, and County of Licensee Investigated:
Amira Choice Bloomington
5501 American Blvd West
Bloomington, MN 55437
Hennepin County

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

Evaluator's Name: Julie Serbus, 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 wound cares were not followed as ordered.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While the resident had recurring blisters and wounds, the facility coordinated cares with the hospice provider as the resident's condition changed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice provider and a family member. The investigation included review of the resident record(s), hospice orders, electronic medication/treatment records, staff schedules, related facility policy and procedures. During an onsite visit, the investigator observed the resident being transferred using the Hoyer lift and caregivers providing cares.

The resident resided in an assisted living memory care unit. The residents' diagnoses included bullous pemphigoid (autoimmune disorder which causes large fluid filled blisters) and dementia. The resident's service plan included coordinating wound cares and dressing changes with hospice, two staff to reposition resident every two hours using a Hoyer lift either into her bed, recliner, or specialty wheelchair.

Two months prior, the resident's assessment indicated the resident was admitted for this same skin condition related to bullous pemphigoid. The resident remained in the hospital for intravenous antibiotics, wound cares, and eventually at transitional care unit prior to returning to the facility. When the resident returned to the facility, all the wounds had healed.

The same day she returned to the facility, the resident record indicated the resident was admitted to hospice care.

A concern arose when seven days after the resident returned to the facility from the hospital a new unopened blister was reported. -

The facility updated hospice when the first blister occurred. The resident record indicated a week after the first blister was noted, additional blisters continued to form and the treatment for the intact blisters included a topical cream. The facility continued to communicate skin changes with hospice. The facility nursing department and unlicensed caregivers realized these blisters were likely a recurrence of bullous pemphigoid. Within two weeks of the initial blister(s), the medical provider initiated treatment including antibiotics, prednisone, and wound dressings.

Hospice provided dressing care orders once the blisters started opening and forming wound with dressing changes three times a week. The order was to cleanse the affected wounds with wound cleanser, pat dry, apply xeroform gauze, and cover with mepilex.

The progress notes indicated on more than one occasion dressings were not properly applied as xeroform (used as a barrier between skin and adhesive part of mepilex) was not placed as ordered causing the sticky part of dressing to pull off tissue from the wound. This caused the condition of the skin to deteriorate and open the wounds making dressing changes extremely painful for the resident. Hospice ordered the resident to receive as needed pain medication 30 minutes prior to wound care. The facility licensed nurses and licensed hospice nurse were the only ones authorized to perform dressing changes.

During an interview, the facility nurse stated when blisters would appear they were not considered wounds and dressing changes were not warranted. The nurse stated at times blisters would open and dry out not causing a wound but other times these blisters would open up without drying up causing a wound. The facility nurse stated wound care and dressing changes were ordered by hospice. Oral medications were prescribed with the dosages adjusted as needed. Two months after the resident had returned from the hospital the medical provider

diagnosed resident's skin condition, and prescribed prednisone to treat the condition and adjust dosages as blisters would occur. The original order for topical cream and antibiotics was discontinued and hospice received wound care and prednisone orders to be completed both by licensed nurses at the facility and hospice. The nurse stated hospice provided dressing changes once a week while the facility would complete the dressing changes twice a week. The orders for prednisone and dressing changes did change often based on the resident's condition. The nurse stated multiple care conferences with the health care team and family were scheduled to discuss concerns and any changes in care.

During an interview, a hospice nurse stated there were concerns when dressing changes were not applied as ordered causing tissue to be adhered to the adhesive part of the dressing. The nurse stated this caused the wound to be at their worst and the resident would experience extreme pain with the dressing changes if not applied as ordered. The nurse stated dressing changes were scheduled three times a week with hospice nurse to complete one of the changes and the facility nurse to complete the other two weekly dressing changes and as needed for excessive drainage or if the dressing would come off. The nurse stated multiple times re-education was provided to family and facility staff on appropriate dressing changes to avoid causing unnecessary pain and tissue damage.

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, non-verbal
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: Continued coordination with hospice regarding the resident's caes.

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
	36899	A. BUILDING: _____ B. WING _____	C 03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE OF BLOOMINGTON LLC	5501 AMERICAN BOULEVARD WEST BLOOMINGTON, MN 55437

(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 24, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL368999644C/#HL368998282M. No correction orders are issued.	0 000		