Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL333582768M
Compliance #: HL333584698C

Date Concluded: January 18, 2023

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:
Katie Germann, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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) abused a resident when she forcefully grabbed the resident's arm and turned the resident when assisting the resident with cares causing the resident pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP was observed on video forcefully pulling on the resident's arm to turn the resident while the resident cried out in pain. The AP continued to forcibly push the resident from side to side after the resident expressed pain.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted the resident's family and the AP. The investigation included review of resident medical records, employee files, facility 24-hour reports, facility policies and procedures, facility investigation, and training records. Also, the investigator observed staff cares and video of the incident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, osteoarthritis, spinal stenosis, and polyneuropathy. The resident's service plan included assistance with activities of daily living, medication administration, toileting assistance, bathing assistance, housekeeping, and laundry. The resident's assessment indicated cognitive impairment due to late-stage Alzheimer's disease, requiring supervision and assistance with all cares.

A facility investigation of the incident indicated the resident's family member had concerns of rough treatment observed on the video camera placed in the resident's room. The facility staff observed the video and found the video to show "clear video of neglect/abuse". According to the internal investigation the AP was, "rough with resident, slapping resident's hand away, yelling at her to stop pulling on shirt, then roughly rolling her after pulling on her arm." The internal investigation indicated the resident was unable to report abuse due to late-stage Alzheimer's disease.

During an overnight shift, the AP went to a resident's room to change a soiled brief. Review of the recorded video of the incident shows the resident covered with her blankets in bed. The AP approached the resident and pulled the covers off the resident. The AP then removed the resident's brief and threw the soiled brief on the carpeted floor. The resident could be heard saying "Ow" and was attempting to cover herself up with her T-shirt. The AP did not acknowledge the resident's pain, the AP told the resident, "You're wet!" The AP was observed continually pushing the resident's hands and t-shirt out of the way and telling the resident to "stop" and "stop moving" when the resident was trying to cover herself up with her shirt. The AP then restrained the resident by holding the resident's hands down with one hand while attempting to change her brief with the other hand. The resident was lying on her back when suddenly the AP leaned over the resident and grabbed the resident's left arm and pulled with force, rapidly turning the resident's entire body toward the AP, causing the resident to cry out, "Ow". The resident continually said, "Oooohh, ooohh" appearing to be in pain, while waving her hands. The AP ignored the resident's moans and cries of pain and continued to change the resident. The resident turned herself onto her back, continuing to try and cover the bottom half of herself with her hands and T-shirt. The AP continued to say, "stop, let me change you" and "it's wet, you need to wait". The AP completed cares and asked the resident, "Why do you keep fighting?" and "we are trying to help you". The AP covered the resident with blankets, cleaned the soiled brief off the floor, while continuing to say to the resident, "Why you fight when we are trying to help you?" The AP turned off the light and walked out of the room.

During an interview, a nurse stated she was made aware of the incident when she received an email from the resident's family with video of the incident. The nurse reviewed the video and reported the incident to her supervisor.

In an interview, a residents family member stated they reviewed camera footage of the incident and immediately reported it to the facility administration by email. The family stated the

resident typically had two staff members help her with toileting overnight and the resident normally uses the bathroom and was not changed in bed. The family member stated the resident has moved to another facility because of the incident.

When interviewed the AP denied being rough with cares.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: No, unable.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility filed a MAARC report and initiated an internal investigation. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.
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

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 12/13/2022

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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. 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. INITIAL COMMENTS: #HL333584698C/#HL333582768M On December 13, 2022, 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 95 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL333584698C/#HL333582768M, tag identification 2360.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	