Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL335993625M
Compliance #: HL335996016C

Date Concluded: July 12,2023

Name, Address, and County of Licensee Investigated:
Amira Choice Plymouth
18405 Old Rockford Road
Plymouth, MN 55446
Hennepin County

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

Evaluator's Name: Holly German, 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 a resident when staff failed to provide supervision and safety checks during the night. Staff found resident on the floor. The resident was on the floor for an undetermined amount of time. Resident was admitted to the hospital with a leg fracture and passed away hours later due to complications from the fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and sustained a fracture, the residents service plan was followed at the time the incident occurred. The facility sent the resident to the emergency room (ER) appropriately. The facility provided for the resident's toileting assistance according to the resident's individualized care plan. The resident was independent with transfers and walking.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, a family member, and unlicensed staff. The investigation included review of

resident records, hospital records, facility internal investigation, and facility policies. Also, the investigator observed interactions between residents and staff members.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, Atrial fibrillation (an irregular and often very rapid heart rhythm) and congestive heart failure. The resident's service plan included assistance with toileting, dressing, medication administration and bathing. The resident's assessment indicated he was independent with transfers and walking. The resident's service plan included offering toileting assist overnight at 1:00 a.m. and 4:00 a.m.

An incident report indicated the resident stated he was trying to get to bed. Facility documentation and the resident's medical record indicated the resident's service plan was followed at the time of the fall.

Hospital records indicated the resident was sent to the emergency room for evaluation after the fall when episodes of "passing out" occurred. The resident was diagnosed with a left hip fracture. The resident passed away at the hospital from complications of left hip fracture.

During an interview, nursing management stated the facility conducted an internal review of the events, and all policies and procedures were followed.

Investigative interviews concluded staff were aware of and follow protocols when a fall occurs.

During an interview, a nurse stated the resident was sent to the emergency room once signs and symptoms of possible serious issues presented.

During an interview, a family member stated they were very happy with how the incident was handled, and how she was kept informed. She did not have any concerns with care received at the facility.

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 deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	33599	A. BUILDING: _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE PLYMOUTH	18405 OLD ROCKFORD ROAD PLYMOUTH, MN 55446

(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 July 12, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL335996016C/#HL335993625M. No correction orders are issued.	0 000		