Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL335998645M
Compliance #: HL335996143C

Date Concluded: February 20, 2024

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

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

Evaluator's Name: Nicole Myslicki, 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 staff failed to provide the appropriate level of care during a change in condition. The resident aspirated during a meal and staff failed to provide safety checks during end of life.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. After the resident aspirated, the facility contacted hospice, administered as needed medication, and assessed and monitored the resident until she returned to her baseline before assisting her to bed. During the night, the facility staff checked on the resident and noticed a change in the resident's breathing and level of consciousness. The staff notified the on-call nurse and administered as needed medications. Although staff missed one scheduled toileting service, the missed service could not have impacted the resident's outcome.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, hospice record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed safety checks and staff assisting a resident to eat.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with medication administration, safety checks every two hours, toileting 10 times daily, and repositioning five times daily. The resident's assessment indicated the resident had a mechanical soft diet (a modified diet that restricted foods that were difficult to swallow) and required assistance to eat meals.

The resident's hospice record indicated the resident likely aspirated while eating dinner, and secretions were observed by staff. The nurse assessed the resident who could cough hard enough to cough out the objects. The resident's lung sounds were clear, and she showed no signs of pain with facial expressions and posture. The hospice nurse called family to update on the incident. Family stated this was normal, and the resident often aspirated. Family also stated that even if the resident could not cough it out and got pneumonia from the aspiration, they would feel okay about it.

A progress note in the resident's record indicated approximately five weeks later, the resident experienced gurgling and phlegm after eating. The resident could speak with ease and denied pain. The nurse administered hyoscyamine (a medication to help with oral secretions) and brought her wheelchair next to the medication cart to be monitored. The nurse called hospice who instructed facility staff to administer morphine (a medication used for pain and shortness of breath) and more hyoscyamine if needed. The nurse contacted family who reported this had happened before.

Another progress note indicated staff called the on-call nurse approximately eight hours after the aspiration to report the resident's breathing changed, she had a low oxygen saturation percentage, and her hands, arms, and neck were starting to turn blue. The resident's eyes were open but not responsive. The on-call nurse instructed staff to administer morphine, then called hospice to update them on the change of condition. Multiple progress notes after indicated facility staff were in communication with hospice regarding the resident's decline, medication order changes, and noting the resident's apparent comfort.

A progress note indicated the resident died approximately a day and a half after the resident aspirated.

The resident's death record identified the cause of death as neurocognitive disorder with lewy bodies (a form of dementia).

During an interview, unlicensed personnel (ULP) 1 stated she had been assisting the resident to eat dinner in the dining room. The resident started choking, so ULP 1 called a nurse who came and assessed the resident. ULP 1 brought the resident close to the medication cart to be monitored by staff. Approximately four hours after the resident aspirated the loud gurgling improved, and ULP 1 assisted the resident to bed as directed by a nurse. ULP 1 raised the head of the bed and assisted her into a comfortable position.

During an interview, ULP 2 stated during the night shift, she received a call from ULP 3, informing her something was wrong with the resident. ULP 3 asked ULP 2 to come to the memory care unit and see the resident. As ULP 2 arrived outside the resident's room, she could hear her breathing had been completely different from her baseline. They turned the light on and observed the resident appeared pale. They called the on-call nurse who instructed them to make sure the resident was comfortable, and the on-call nurse called hospice. ULP 2 then went back to the assisted living to answer call lights while ULP 3 assisted residents on the memory care unit. ULP 2 stated at the beginning of the night shift, she and ULP 3 were not informed the resident's condition had changed. ULP 2 stated upon hire, she had been instructed not to put the light on while the resident slept when completing safety checks at night. Instead, they opened the door enough to listen for breathing and make sure residents were not on the floor.

During an interview, ULP 3 stated was instructed not to put the light on during safety checks at night. Instead, her instruction included opening the door and listen to their breathing, not letting too much light in. ULP 3 had not received a report at the beginning of the shift about the resident's change in condition. ULP 3 stated the first time she completed a safety check on the resident, she had been breathing normally. The second time ULP 3 went to the resident's apartment, the resident had been wheezing, breathing like someone trying to catch their breath.

During an interview, a nurse stated the nurse did not think there had been any changes to what the resident could eat after the first aspiration incident. The resident had been fairly stable, declining slowly over time. The resident left the facility for a period of time, due to family wanting her to pass away at home with family but later returned her to the facility. The nurse coached the overnight staff about the investigation, documenting properly, and the importance of addressing all scheduled tasks. Staff were emphatic they completed the scheduled safety check due around 11:30 p.m., and the resident did not appear to be in distress at that time. The nurse stated they also discussed the incident, the importance of following the schedule and completing shift-to-shift reports in their stand-up meetings. The facility posted signage regarding the process for a change of condition. The nurse watched surveillance footage from the time of the incident. The nurse could see activity in the hallway that looked like the overnight staff looked in the room around 10:30 p.m.

During an interview, a family member stated she had been with the resident until dinner time the day of the incident. The resident seemed to be at her baseline at the time she left. About an hour and a half later, she received a call from a nurse at the facility informing her the resident

aspirated on rice again. The facility administered hyoscyamine for secretions and they would alert hospice. The family stated their apartment video footage showed staff placed the resident in bed at 9:00 p.m., and no one came to check on her until 2:30 a.m. Approximately an hour later, staff called to inform the family member of the resident's rapid decline and labored breathing. The family member stated when she arrived, the resident was alone, eyes wide open, and having a difficult time breathing. The family member thought the resident suffered unnecessarily, and comfort care could have been implemented.

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

Action taken by facility:
The facility completed an internal investigation, coached overnight staff on the importance of completing and documenting all services, and educated all staff on what to do when a resident had a change of condition. Additionally, the facility held a meeting with family and hospice.

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 01/17/2024

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 January 17, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL335996143C/#HL335998645M. No correction orders are issued.	0 000		