DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL368998288M **Date Concluded:** March 19, 2024
Compliance #: HL368995475C

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

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

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Inconclusive

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):
An unknown facility staff member/alleged perpetrator (AP) neglected the resident when they removed his call pendant for the duration of the night shift and did not return the call pendant until the next morning. In addition, staff did not complete toileting or repositioning assistance as directed by the resident's plan of care.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It was unable to be determined if neglect occurred. The resident could not recall specific details of the incident, and the staff member/alleged perpetrator (AP) denied removing the call light from the resident's room. Documentation reviewed indicated care and services were provided in accordance with the resident's service plan on the night of the alleged incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted outside agency nursing staff

and the resident's family. The investigation included review of the resident's record, facility documentation, personnel files, staff schedules, call light logs, and facility policies and procedures. At the time of the onsite visit, the investigator observed care provided to the resident.

The resident resided in an assisted living facility. The resident's diagnoses included transient ischemic attack (TIA) (short periods of symptoms similar to a stroke). The resident's service plan included assistance with activities of daily living (ADLs), including staff assistance with catheter care, medication management, and two-person assistance with the use of a mechanical lift for repositioning, toileting, and transfers. The resident's assessment indicated that the resident was independent with the use of his call pendant, had no communication deficits, and was able to provide accurate information.

Complaint documents indicated a night shift staff member said to the resident, "Oh, I have heard about you before. You like to press your call pendent too much" and removed the resident's call pendant from his room. No staff returned to provide care or check on the resident for the remainder of the night, and the staff member returned the call pendant to the resident in the morning.

A facility investigation identified a staff member/alleged perpetrator (AP) who worked the night of the alleged incident. The AP denied removing the call pendant from the resident's room and told administrative staff that she placed it on the resident's overbed table and positioned the table within the resident's reach.

Review of facility call pendant records indicated the resident's call light was not activated on the night of the alleged incident.

Facility documentation identified the resident's care plan was followed the night of the alleged incident.

Staff who worked the morning after the alleged incident stated the resident had his call light at the beginning of their shift, and the resident did not report any concerns regarding the night shift.

During an interview, facility administrative nursing staff indicated they investigated the incident but were unable to determine if the incident occurred. Administrative staff stated they retrained all staff after the incident on the importance of residents having their call light within reach.

During an interview, the resident's family indicated they were aware of the incident but could not recall if any follow up was completed by the facility.

During an interview, the resident was unable to recall specifics of the incident.

The AP declined to be interviewed.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: Yes
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No; AP declined to interview.

Action taken by facility:
The facility completed an investigation of the allegation and retrained staff.

Action taken by the Minnesota Department of Health:
No action taken

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 01/31/2024

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 January 31, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL368995475C/#HL368998288M. No correction orders are issued.	0 000		