Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL335991621M
Compliance #: HL335996322C

Date Concluded: June 4, 2026

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: Maerin Renee, 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 alleged perpetrator (AP) physically abused the resident when he handled the resident roughly during cares and grabbed his arm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although the incident occurred, the actions of the AP did not meet the definition of abuse. The resident sustained no injury and the AP's employment was terminated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, death record, the facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report,

and related facility policy and procedures. Also, the investigator observed resident care and interactions with staff.
The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease. The resident's services included assistance with activities of daily living, meals, and medication management. The resident's assessment indicated the resident was oriented to person only and was hard of hearing.

Facility documentation indicated administration was alerted to concerns with the AP's treatment of the resident after a review of camera footage.

Camera footage reviewed of the incident showed the AP assisting the resident to his room and to his bed. The AP did not allow the resident time to transfer into bed, instead placed his arm around the resident's waist and forcefully pushed the resident around onto the bed. The AP forced the resident's upper body into the bed. The resident swatted at the AP with his left arm as he lay on the bed. The AP held the resident's legs with his left arm and swung them onto the bed, pushing them into place. The AP grabbed a blanket from under the resident and threw it on him. The resident was still dressed in his day clothes, with slippers on. The AP said, "Jeez, why do you gotta be so mean? Good lord!" The AP walked away and paused, appearing to notice the camera in the room. The AP walked out of frame and then returned a short time later. He approached the bed, handled the resident's bed control, then moved to the head of the bed. The AP said, "Here, put your head up on the pillow." He grabbed the resident's shoulders while the resident resisted. The AP said, "Ok, ok!" and rearranged the resident's blanket. The AP walked away and exited the frame whispering, "What is happening? So many cameras…" The video clip ended.

Facility administration reported the incident and initiated an internal investigation. The resident was assessed and had no evidence of injury sustained from the incident. Following the investigation, the AP's employment was terminated, and staff were retrained regarding vulnerable adult statutes.

A police report indicated the family did not want to press charges and they were grateful for how the facility handled the incident. The detective documented the report as an informational report only and no charges were filed.

When interviewed, a supervisor said the resident could not problem-solve, reason, or sequence, so he required full hands-on care. The supervisor had reviewed the camera footage and said the resident had not been able to follow the AP's commands due to his dementia, triggering the AP to manhandle the resident. The supervisor said the AP did not follow protocol while transferring the resident and did not consider the AP's treatment of the resident to be acceptable.

When interviewed, a family member said the resident's Alzheimer's disease was advanced and he did not comprehend staff instructions. The family member was distraught by what the

camera footage revealed but was pleased with how the facility responded. The family member felt the facility took appropriate action and followed up in an acceptable manner.

When interviewed, the AP said he helped the resident back to his room. The resident was agitated and would not let go of the AP's arm. The AP said he was a little stressed, and the AP tossed the resident into bed. The AP said he received some training about managing agitation in residents but did not feel it was very much. The AP said he was a little burned out and knew tossing the resident into bed was not the appropriate thing to do, but the resident would not let go of his arm. The AP said it was all caught on camera so he did not know what else he could say.

In conclusion, the Minnesota Department of Health determined abuse 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.

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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

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

Action taken by facility:
Facility leadership re-educated staff regarding vulnerable adult statutes and provision of care.
The AP is no longer employed by the facility.

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 03/17/2026

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 March 17, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL335991621M/HL335996322C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	