Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL217874102M
Compliance #: HL217877987C

Date Concluded: October 16, 2025

Name, Address, and County of Licensee Investigated:
Sunrise of Edina
7128 France Avenue South
Edina, MN 55435
Hennepin County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 the resident's plan of care was not followed resulting in a hospitalization due to a wound to the resident's toe.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident sustained a wound to his right toe and the facility failed to assess the wound for four days, the error was an isolated incident. Etiology of the wound was from chronic health conditions and would not have changed the treatment if the facility assessed the wound four days prior. The resident was sent to the hospital and had a partial amputation completed to the toe.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records,

hospital records, facility, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included psychoactive substance abuse, opioid abuse, bipolar disorder, and depression. The resident's service plan included assistance with applying and removing compression wraps, toileting, observing skin for changes, and bathing. The resident's assessment indicated the resident had impaired cognition related to stroke and drug use. The resident's assessment indicated the resident's skin was at risk for breakdown because of impaired mobility, blood circulation issues, and edema.

The resident's medical record indicated one day the resident was found with a new open area on his foot. The medical record indicated in the days prior to the resident's toe wound being found, the resident had no skin concerns. The medical record indicated four days after the open area was found, the resident was sent to the hospital for further evaluation.

The resident's medical record lacked a wound assessment completed by a nurse.

The hospital record indicated the resident's toe wound was "likely" from drug abuse that caused skin tissue damage and osteomyelitis (an infection of the bone). The resident required a partial big toe amputation and was discharged back to the facility.

During an interview, unlicensed personnel stated they were assisting the resident with removing his compression stockings and observed an open area on his right big toe. The area was cleansed with soap and water. The unlicensed personnel stated they made a note in the resident's medical record about the wound. The wound was found a few days prior to the resident going to the hospital.

During an interview, nursing leadership stated nursing was alerted to the resident's wound by another unlicensed personnel four days after it was documented the resident's medical record. The facility's medical provider assessed the resident's wound, and the resident was transported to the hospital for further evaluation.

During an interview, a family member stated the resident's toe was amputated because of an infection. The family member stated the resident was transferred to a higher level of care.

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 no longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility requested a medical provider to evaluate the resident’s toe and transported the resident to the hospital for further evaluation.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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
	21787	A. BUILDING: _____ B. WING _____	C 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE OF EDINA	7128 FRANCE AVENUE SOUTH EDINA, MN 55435

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: HL217874102M/HL217877987C On August 26, 2025, 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 62 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL217874102M/HL217877987C, tag identification 1620.	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.	
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring	01620		

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01620	Continued From page 2 and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to assess a new wound for one of one resident (R1) reviewed. The licensee failed to assess the wound for four days. R1 required a hospitalization and a partial big toe amputation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included psychoactive substance abuse, opioid abuse, bipolar disorder and depression. R1's nursing assessment dated May 7, 2025, indicated R1 had intact skin and was at risk for skin breakdown because of incontinence,	01620		

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01620	Continued From page 3 impaired mobility, blood circulation concerns, and edema. R1's service delivery record indicated on June 12, 2025, at 8:55 p.m., unlicensed personnel (ULP)-B documented R1 had a new open area on his feet. - On June 13, 2025, at 8:18 a.m., a ULP documented R1 had no skin breakdown concerns. - On June 13, 2025, at 7:59 p.m., ULP-B documented R1 had an open area on his feet. - On June 14, 2025, both morning and evening ULPs documentation indicated R1 had no skin breakdown concerns. - On June 15, 2025, at 1:42 p.m., a ULP documented R1 had no skin breakdown concerns. - On June 15, 2025, at 9:59 p.m., ULP-B documented R1 had an open area on his feet. - On June 16, 2025, at 1:00 p.m., a ULP documented R1 was not available. R1's medical record lacked evidence R1's right foot was assessed for four days prior to being evaluated by the licensee's medical provider and being transferred to the hospital. During an interview on August 26, 2025, at 12:19 p.m., registered nurse (RN)-A stated when a resident is found with a skin concern, the ULP is to document the finding in the electronic medical record (EMR), the documentation then sends an alert to the nurse's EMR dashboard. The expectation is that the nurses would respond to the alert on the dashboard and assess the area of concern by the next day. During an interview on August 27, 2025, at 10:17	01620		

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01620	Continued From page 4 a.m., ULP-B stated R1's wound was found Thursday night while providing cares. ULP-B stated R1's new wound was charted in the EMR, and it was expected a nurse would see R1 the next day. During a follow up interview on August 28, 2025, at 11:58 a.m., RN-A stated the wound was documented in the service delivery record on August 12, 2025, however R1's wound was not assessed until August 16, 2025 when assessed R1 was transferred to the hospital for further evaluation of the toe wound. RN-A stated a nurse should have assessed R1's wound the next day on August 13, 2025. R1's medical record lacked evidence that a licensee's nurse assessed the wound. A change in condition policy was requested but not provided by the licensee. TIME PERIOD FOR CORRECTION: Seven (7) Days	01620		