Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL217876286M
Compliance #: HL217879472C

Date Concluded: February 5th, 2025

Name, Address, and County of Licensee Investigated:
Sunrise of Edina
7128 France Avenue South
Edina MN 65435
Hennepin County

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

Evaluator's Name: James P. Larson, 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 they failed to provide fall precautions after the resident previously had unwitnessed falls in her apartment. The resident then fell again and sustained injuries that required advanced care and intensive care hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility followed the care plan, performed safety checks, and implemented fall precautions as directed. There was not a preponderance of evidence to support that the actions of the facility staff met the definition of neglect.

The investigator conducted interviews with facility staff members, including nursing staff. The investigation included review of the resident record, the facility internal incident reports, personnel files, employee training files, and facility policy and procedures. The investigator also toured the facility and observed staff members interacting with residents.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included dementia, psychotic disturbance, and anxiety. The resident's service plan included assistance with all activities of daily living, routine safety checks, and medication administration. The resident's assessment indicated the resident had a history of unwitnessed falls with injury and required supervision due to impaired cognition.

Records reviewed indicated the resident had history of falls with injury at her home prior to her admission to the assisted living. Records further indicated that the resident was independent with ambulation upon admission to the facility, although at times showed signs of compulsive behavior when attempting to assist facility staff with tasks. In the weeks and days leading up to the injury, facility staff recorded unwitnessed falls that had occurred in both common areas of the memory care unit and the resident's apartment.

The day of the incident, two separate unwitnessed falls occurred. The resident first fell in her apartment and facility notes indicated that the resident reported to staff that she was making her bed when she tripped on something and fall. Later that afternoon, staff members found the resident on the floor in her apartment, and she appeared to have lost consciousness. The facility collaborated with the resident's family, and it was decided that she should be transported to a local hospital for evaluation. The resident was found to have significant brain and back injuries and upon returning to the facility days later, was admitted to Hospice care.

During an interview, a registered nurse (RN) stated she was aware of the resident's history of falls prior to admission to the facility. Continuous revisions to the resident's care plan were made throughout her admission to ensure safety, which including increased safety checks when the resident was in her apartment and not engaging in activities in the common area. The nurse stated that she witnessed the resident abruptly falling with no warning and facility staff were aware of this and increased supervision and monitoring of the resident.

During an interview, a family member stated that they were contacted and informed of the incidents by the facility and that they had no concern with care provided by 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, Unable
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The nursing staff identified fall vulnerabilities in the nursing assessments and addressed ongoing precautions in the care plan to identify potential and actual risk for falls and injury.

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
	21787	A. BUILDING: _____ B. WING _____	C 01/13/2025

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 On January 13, 2025, the Minnesota Department of Health initiated an investigation of complaint ##HL217879472C/#HL217876286M. No correction orders are issued	0 000		