Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL217877322M
Compliance #: HL217872460C

Date Concluded: February 12, 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: Jennifer Segal, RN, BSN
Special Investigator

Finding: Substantiated, facility responsibility

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 developed a pressure sore on his left hip. The facility failed to provide repositioning assistance and the pressure sore worsened. The resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility identified the resident had a new pressure sore on his left hip and failed to develop and implement interventions to prevent the pressure sore from worsening. Over approximately two weeks, the pressure sore more than tripled in size and became infected. The resident required hospitalization for severe sepsis (life-threatening infection) secondary to the pressure sore on his hip. In addition, during the same time, the resident developed additional pressure sores and skin tears.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the outside home care agency and the resident's family. The investigation included a review of medical records from the facility, hospital, outside home care, and primary care providers. The investigation included a review of staff records and related facility policies. In addition, the investigator observed staff members provide care to other residents.

The resident resided in an assisted living facility with diagnoses including diabetes. The resident's service plan indicated the resident was blind and required staff assistance with all personal care, including mobility with two staff members and a mechanical lift, repositioning three to four times a shift to prevent pressure sores, catheter care, and skin care. The resident's assessment indicated the resident was frail and at risk of skin breakdown, pressure sores, and poor wound healing.

Unlicensed staff notified facility nursing staff the resident had a new open area on his left hip. Nursing staff assessed the left hip and observed a new pressure sore described as pink with a tinge of red and measured 1.5 centimeters (cm) length x 1.0 centimeters width and zero depth. The resident complained of pain around the sore during care and repositioning. Nursing staff cleansed the sore, applied barrier cream and covered the sore with a band aid and indicated the outside home care nurse would follow up.

The next day an outside home care agency nurse assessed the resident's left hip and indicated a new unstageable, necrotic (dead or non-viable tissue), pressure sore measuring 0.7 cm x 1 cm x 0.1 cm. The nurse covered the pressure sore and visited again the same week.

The following week the residents medical record indicated nursing staff assessed the pressure sore and observed a small amount of thick and foul-smelling drainage from the pressure sore. No new interventions were added to the resident's plan of care.

Three days later the outside home care agency indicated the resident’s pressure sore on the left hip measured 7 cm x 5 cm x 0.2 cm. The outside nurse directed the resident and staff to have the resident stay off his left hip and turn and reposition the resident every two hours. There was no indication the intervention was implemented or that direction was given to staff to ensure the resident was repositioned every two hours and stayed off his left hip.

Three days later the residents medical record indicated a facility nurse applied a new dressing to the pressure sore and observed a moderate amount of foul-smelling drainage from the pressure sore. There was no indication the nurse reported the change in the resident’s pressure ulcer to the physician.

The next day the outside home care agency records indicated the outside agency came to the facility to see the resident. The residents left hip wound appeared worse and the resident had

several new wounds on the buttocks, testicles and penis. The home care nurse notified the on-call provider who directed the resident go to the hospital.

The hospital record indicated suspicion of necrotizing infection and severe sepsis secondary to the left hip pressure sore. The hospital records indicated the resident had newer pressure sores to the right ankle, right foot, and left heel. The resident's buttocks, coccyx, and right hip had redness and scabbing. The resident's penis and scrotum had scattered areas of necrotic tissue related to pressure and moisture from the residents indwelling urinary catheter. The hospital record indicated the resident's left hip pressure sore would not respond to antibiotics and the resident would require surgical intervention. The resident declined surgical intervention and returned to the facility 5 days later with end-of-life care.

The resident's death record indicated the resident died of natural causes with contributing factors including infected pressure ulcer left hip.

During interviews with the outside home care agency staff, they stated when they came to the facility, they usually found the resident lying in bed on his left side. The home care staff stated they had frequent discussions with facility staff about the importance of repositioning the resident every two hours and ensuring the resident was not laying on his left side. They also stated the staff were not completing adequate hygiene of the resident and the indwelling urinary catheter.

During interviews multiple unlicensed facility staff stated they made frequent verbal and written reports to facility nursing staff regarding changes in the resident's skin condition including redness, open areas, and skin tears.

During interview a facility nurse stated the resident received daily wound care for the left hip pressure sore which was in addition to the outside home care agency. The nurse stated the facility did not document the daily wound care that was completed, nor did the facility have physician orders on the care to provide to the residents left hip pressure sore during that time.

During interview facility leadership stated although the residents medical record lacked documentation regarding the frequency of repositioning, leadership stated they were confident the staff provided repositioning three to four times per shift because staff were always in the resident's apartment. Leadership stated the facility documentation in the resident's medical record regarding the resident's left hip sore were notes made by the outside home care agency that was copy and pasted into the resident's facility medical record. Leadership stated they had no documentation of obtaining a specialized mattress for the resident, a bed rail, or cushion for the wheelchair prior to the resident's hospitalization. Leadership stated they had no further information available regarding physician orders for wound care, staff training, and orientation specific to resident-changing needs and skin care.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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

Action taken by facility:
Provided education for proper documentation of services.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Hennepin County Attorney
Edina City Attorney

Edina Police Department
Minnesota Board of Nursing

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 01/06/2025

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: #HL217877322M, #HL217872460C. On January 6, 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 65 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL217877322M, #HL217872460C tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		