Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL421651980M
Compliance #: HL421657520C

Date Concluded: July 16, 2026

Name, Address, and County of Licensee Investigated:
First Light Residential Care
6338 Girard Ave S,
Minneapolis, MN 55423
Hennepin County

Facility Type: Assisted Living Facility (ALF)

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 had a change in condition and failed to follow the provider orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had arteriosclerotic cardiovascular disease (occurs when cholesterol and fatty deposits form plaque inside your arteries, narrowing them and restricting blood flow) and a history of edema in his legs. The provider ordered medication and compression wraps, however the resident refused to wear the compression wraps because they hurt his legs. The provider was aware the resident refused the wraps; occupational therapy was ordered and the edema decreased.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care provider's team.

The investigation included review of the resident records, and staff schedules. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis and arteriosclerotic cardiovascular disease (occurs when cholesterol and fatty deposits form plaque inside your arteries, narrowing them and restricting blood flow). The resident's service plan included assistance with dressing, grooming, and medication administration. The resident's assessment indicated the resident was alert and oriented, had edema in his legs and required assistance with applying and removing compression stockings.

The resident record indicated the resident had edema in his lower legs. A provider ordered medication to treat fluid retention, and compression wraps for the resident to wear every day. The resident record indicated the resident took the medication as prescribed but did not like to wear compression wraps because they increased the pain in his legs. The resident record indicated the resident would limit adding additional salt to food and would elevate his feet when sitting in a chair or lying in bed to help reduce the edema in his legs.

During an interview, multiple unlicensed staff stated the resident did not like to wear his compression wraps because it caused him too much pain.

During an interview, the facility nurse stated the resident had edema in his legs for a long time. The resident was also prescribed a medication to reduce the edema in his legs. The facility nurse stated the resident did not like to wear the compression wraps because they were uncomfortable and caused pain. The resident also did not like taking the medication because it made him urinate frequently. The facility nurse stated staff encouraged the resident to elevate his legs when he was sitting in a chair. When the resident was lying in bed, staff put pillows under his feet to elevate his legs to help reduce the edema. The resident was also seen by physical and occupational therapy for the edema.

During an interview, the resident stated he had edema in his legs, and that staff knew how to apply compression wraps. The resident stated he did not like to wear compression wraps because they caused pain in his legs. The resident stated he received medication for edema and would elevate his legs when sitting in a chair.

During an interview, a member of the primary care provider team stated the team was aware the resident did not like to wear the compression wraps and that medication was ordered to help reduce the edema for the resident's legs.

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: Yes.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action required.

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
	42165	A. BUILDING: _____ B. WING _____	C 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST LIGHT RESIDENTIAL CARE	6338 GIRARD AVENUE S RICHFIELD, MN 55423

(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 July 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL421651980M / #HL421657520C. No correction orders are issued.	0 000		