Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL217877668M
Compliance #: HL217874542C

Date Concluded: March 7, 2024

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

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

Evaluator's Name: Danyell Eccleston, RN
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 facility failed to provide skin integrity monitoring. The resident sustained a pressure injury to her left lower leg that required follow-up care. The pressure injury worsened and required treatments and procedures for several months.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to check the skin under and remove the resident's removable leg brace which created a pressure ulcer that went through the resident's skin to tissue underneath. The pressure injury worsened into a greater wound that required debridement, surgical interventions, and skin grafts.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the outside agency that provided physical therapy, occupational therapy, and wound care to the resident during the time in

question. The investigation included review of medical records, staff records, and policies. The investigator observed staff members providing care to residents.

The resident resided in an assisted living facility. The resident's diagnoses included a healing left leg fracture, non-weight bearing status to left leg, and falls. The resident's service plan included transferring in and out of bed, monitoring of surgical wound, and physical and occupational therapy three times per week by an outside agency. The resident's assessment indicated the resident was at risk for skin issues and that skin would be observed for changes.

Assessment documentation three days prior to admission indicated the resident had a surgical wound to her left leg, no other skin wounds were noted. The assessment also indicated the resident needed to be monitored for any increased pain, skin changes, and swelling.

Discharge instructions from the transitional care facility indicated the resident needed assistance to put the immobilizer brace on her leg and was to continue to be non-weight bearing. The discharge documentation also indicated there was a small pink spot on the resident's left outer ankle.

Progress notes indicated the resident arrived at the facility from a transitional care center with a cast (brace) on her left lower leg and had very dry skin.

Progress notes from day four of admission indicated facility staff contacted the medical provider to obtain a wound care order. The note indicated the outside company providing therapies were not able to provide wound care at the time. No further details regarding the resident's skin were noted in the progress note.

Progress notes from day seven of the admission indicated the resident had a 4 x 2 (form of measurement not indicated) wound on her left ankle and outside skilled nursing would complete wound cares every other day and as needed.

A photo from day eight of admission showed a pressure injury to the resident's left outer ankle that was dark in color with the tissue below the skin exposed.

During an interview, a nurse stated residents coming from a transitional care unit would be assessed for needs regarding braces and skin care prior to coming to the assisted living facility and a plan would be in place upon admission. However, when the resident came to the facility a plan and doctor orders were not in place regarding removal of the resident's brace or care of her surgical wound. The facility attempted to contact the doctor to obtain orders after the resident was admitted. The nurse stated the resident was at the facility several days when a nurse from an outside agency showed the nurse the pressure wound on the resident's lower leg. The wound went through the resident's layer of skin to the tissue beneath.

During an interview, a leadership member stated the resident admitted to the facility after experiencing a leg fracture and needed to become stronger to be able to go home. The leadership member stated the facility did not take off the removeable brace the resident wore on her left leg which caused a wound.

During an interview, a family member of the resident stated the wound to the resident's lower leg led to skin and tissue issues around the entire lower leg. The resident had multiple procedures on her left leg, including two surgical wound debridement procedures (procedure where dead and infected tissue is removed), a procedure to increase blood flow, and a skin graft. Eight months later, the resident is still experiencing left leg wound issues and has not been able to return to live with her spouse because of the care she needs.

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 due to current state.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility conducted an internal review of the incident.

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

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 01/09/2024

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: #HL217874405C /#HL217877666M #HL217874542C/ #HL217877668M On January 9, 2024, 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 63 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL217874405C/#HL217877666M, and #HL217874542C/#HL217877668M, 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	02360		

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02360	Continued From page 1 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure two of two residents reviewed (R1,R2) were 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 reports for details.	02360		