*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL282169302M
**Compliance #:** HL282168041C

**Date Concluded:** May 1, 2025

**Name, Address, and County of Licensee Investigated:**
Vernon Terrace Edina
5250 Vernon Avenue
Edina, MN 55436
Hennepin County

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

**Evaluator's Name:** Lissa Lin, RN
Special Investigator

**Finding:** Inconclusive

**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:**
The facility neglected the resident when they failed to provide her with a way to summon help. The resident fell in her apartment, was hospitalized with dehydration and acute kidney injury.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was inconclusive. The facility did not provide their emergency call pendants to all their housing only residents, only residents who chose to have services. Instead, the facility offered an additional elective service that provided a call pendant and once daily safety check phone call for a monthly fee, creating the option to waive the facility's minimum requirement to provide a means for residents to summon staff for assistance or emergencies. The resident owned a call pendant from an outside service but was not wearing it when she fell because she was charging it. It was inconclusive if she had a facility-provided pendant if she would have worn the pendant not having a need to charge it, therefore having an ability to summon staff to assist her sooner. The resident laid on the floor for a long period of time she laid on the floor before a kitchen staff found her.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules and related facility policy and procedures. Also, the investigator observed a housing only resident wearing her call pendant and front door staff monitoring an emergency alarm panel for fire alarms.

The resident lived in an apartment as a housing only resident; not receiving services. Her diagnoses included macular degeneration and corneal transplants. She walked with a four wheeled walker and had a private caregiver visit once weekly to help with bathing and homemaking. She received one meal (breakfast) delivered daily to her door. She had a call pendant purchased through an outside service.

A few days before the resident fell, she was assessed to begin assisted living services. Record review indicated the resident, and her family, had the nursing assessment completed but they wanted time to discuss the possible change and would follow up with nursing if still interested.

The resident's hospital record indicated she went to the hospital by ambulance after she fell in her apartment three days earlier. The resident admitted with dehydration, rhabdomyolysis (a serious condition with muscle breakdown after being in the same position for a long period of time) and a gastrointestinal bleed. The resident did not return to the facility after her hospitalization.

During an interview, the resident's family member said the resident called him from the hospital and said she fell ill over the weekend. Sometime during the night, or early the next morning she had a sudden urge to vomit and as she got out of bed she tripped on her blankets and fell. She was unable to get up and her emergency call pendant and cell phone were not in reach. She told the family member either the pendant was not working or needed a battery charge which was why she was not wearing it when she fell. The resident remained on the floor until Monday morning when a staff member saw a delivered meal package still outside her door. The family member said the resident had to discharge to a new facility that provided higher levels of care. He said the resident was happy at the facility while she lived there and was treated "like a queen." He did not blame the staff for her fall but wished someone had checked on her.

During an interview, the culinary manager said a virus went through the building around the time the resident fell ill. The dining room was closed, and meals were delivered. The resident already had her breakfast delivered daily. Culinary staff packed her meal into a container and then into a brown bag. They hung the bag on the door, knocked and moved on. Culinary staff were not allowed into resident apartments for any reason. The manager said none of the staff reported untouched meal packages outside the resident's door or any calls for help from her when the delivered the meals.

During an interview, the manager said a few years ago the facility had emergency pull cord alerts in all the apartment bathrooms, but the owners removed them. Various emergency alert pendant systems were researched and tried with mixed success. The housing only residents had a choice if they want an emergency call pendant or not. Many opted out because they have cell phones to summon help.

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

**Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.**
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, not available.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Not Applicable.

**Action taken by facility:**
The facility sent the resident to the hospital when she was found.

**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

Minnesota Board of Executives for Long Term Services and Supports

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 28216 | A. BUILDING: _____ B. WING _____ | C 04/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VERNON TERRACE OF EDINA | 5250 VERNON AVENUE SOUTH EDINA, MN 55436 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>HL282168041C/HL282169302M<br><br>On April 17, 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 43 residents receiving services under the provider's Assisted Living with Dementia Care license.<br><br>The following correction order is issued for HL282168041C/HL282169302M, tag identification 460. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 460 SS=I | 144G.41 Subdivision 1 Minimum requirements<br><br>(5) provide a means for residents to request | 0 460 | | |

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| 0 460 | Continued From page 1<br><br>assistance for health and safety needs 24 hours per day, seven days per week;<br>(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;<br>(7) permit residents access to food at any time;<br>(8) allow residents to choose the resident's visitors and times of visits;<br>(9) allow the resident the right to choose a roommate if sharing a unit;<br>(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interviews, the licensee failed to provide the minimum requirement for all residents, including housing only residents, a means to request assistance for health and safety needs 24 hours a day, seven days a week. The licensee failed to provide their emergency response pendant to housing only residents, and provided a means to waive their minimum requirement by requiring the use the an emergency response pendant as an elective service at an additional cost. This deficient practice affected all housing only residents, including R1. R1 did not have facility emegerncy call pendant, fell in her room and had no means to summon staff for help. R1 laid on the floor for a long period of time, at least 24 hours, before being found and sent to the hospital. | 0 460 | | |

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| 0 460 | Continued From page 2<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Review of the licensee's "Independent Living Pricing" information, undated, indicated housing only included:<br>-scheduled group transportation<br>-activities and wellness programs<br>-access to staff 24/7 (24 hours a day, seven days a week)<br><br>The pricing information sheet indicated, residents who were housing only could elect, at a $140 monthly charge, services for a daily safety check ("I'm OK" check) and an emergency response pendant. Additionally, the emergency response pendant could include "incremental charges" for use.<br><br>Review of resident rosters indicated 12 out of 114 housing only residents purchased the elective charge to receive an emergency response pendant.<br><br>Additionally advertising provided to residents included a flyer for a company owned by the same management company as the licensee, offering various types of emergency response devices at an unknown cost that would not summon staff at the licensee, however also within the flyer indicated "in home" response types | 0 460 | | |

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| 0 460 | Continued From page 3<br><br>available were mountable emergency buttons, such as installing in a bathroom, or their push button emergency response pendant that would pair with the staffs mobile devices.<br><br>R1 was housing only resident at the licensee. R1's Resident Agreement, dated December 31, 2024, indicated R1 had housing only and a food plan of one meal per day. She did not have an emergency call pendant provided by the licensee.<br><br>R1's record had pre-admission assessment to start assisted living services, dated February 4, 2025, but had not started services with a service plan agreement.<br><br>Review of resident hospitalizations during February 1, 2025 to April 30, 2025, indicated R1 had an unplanned hospitalization on February 10, 2025, at 9:00 a.m. due to norovirus.<br><br>R1's hospital record dated February 10, 2025, indicated R1 went to the hospital by ambulance after she fell in her apartment three days earlier. R1 was evaluated and admitted with dehydration, tachycardia, atrial fibrillation, rhabdomylosis (condition from being in the same position for a long period of time) and a gastrointenstinal bleed.<br><br>An email dated March 14, 2025, at 9:44 a.m., from R1's family member (FM)-C to licensed assisted living director (LALD)-B, indicated R1 would not return to the licensee because she needed a higher level of cares. In the email, FM-C asked if R1's medical alert device was provided by the licensee or if R1 purchased the device independently. LALD-B's email response indicated R1 was not an assisted living resident and she did not elect the purchased service for an emergency response pendant. LALD-B's email | 0 460 | | |

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| 0 460 | Continued From page 4<br><br>reply indicated in 2023 all the apartment emergency response pull cords (most located in the bathrooms) were removed by previous management. All residents were issued call pendants and the alerts went to the City of Edina. When the City of Edina received 60 false alarms in one month, the licensee had to find a different call pendant option. LALD-B provided a GPS (global positioning system)-based emergency response system for $45 per month or the facility emergency response pendant for $130 per month. Residents were given the option to sign up for either emergency response service. Many of the housing only residents declined either emergency response system. LALD-B did not know what type of call pendant R1 had or if it was in working condition at the time of her illness.<br><br>During an interview on April 17, 2025, at 9:45 a.m., LALD-B said their housing only residents do not have call pendants or daily safety checks. They can purchase the independent living plus package service to get a call pendant or wristband and a daily safety check phone call.<br><br>During an interview on April 17, 2025 at 1:40 p.m., LALD-B said the housing only residents make the final decision on services they want. They have options. They have phones to summon help. She did not know if R1 had a call pendant and if she did, LALD-B said she would not know what service she used. LALD-B said she heard R1 fell in her apartment and was hospitalized.<br><br>During an interview on April 17, 2025, at 1:20 p.m., culinary director (CD)-A stated R1 received one meal daily, breakfast. Kitchen staff deliver meals in a to-go container and hang the meal bag on the residents door; they are not allowed to | 0 460 | | |

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| 0 460 | Continued From page 5<br><br>enter resident rooms. If more than one bag was hanging on the door, CD-A stated kitchen staff would notify someone.<br><br>During an interview on April 22, 2025, at 1:00 p.m., FM-C said R1 told him she felt ill over the weekend and got up from bed, tripped and fell to the floor. She was unable to get up and unsure how long she was on the floor. She could not reach her phone. FM-C stated R1 did not order dinner that weekend and on Monday a staff member saw one of her meal bags outside her door and stopped to check on R1.<br><br>Review of a policy and procedure titled, Pendant and Pull Cord, revised date February 3, 2020, indicated assisted living residents are required to have a call system in place that is answered 24 hours a day. The primary purpose of the pendant call system is to summon staff for health needs including concerns and emergencies. The licensee policy indicated they recognized some residents may use the pendant call system for non-urgent needs.<br><br>TIME PERIOD TO CORRECT: Seven (7) Days | 0 460 | | |