

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304989363M
Compliance #: HL304983560C

Date Concluded: April 27, 2026

Name, Address, and County of Licensee

Investigated:

Vermillion Senior Living
1232 Birch Street North
Tower, MN 55790
St. Louis County

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

Evaluator's Name: Barbara Axness, 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(s):

The facility neglected the resident when staff failed to immediately notify the nurse about a change in condition when the resident couldn't bear weight on his leg. The resident experienced pain and a delay in care.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. Although the nurse was not immediately notified about the resident's complaints of pain, staff administered pain medication. It was unable to be determined if the resident experienced uncontrolled pain after it was noted he unable to bear weight. He was sent to the hospital the following day after complaining of 10 out of 10 pain.

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

investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included history of stroke and weakness. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident could transfer and walk independently with a walker. The resident's pain history included occasional headaches.

Facility records indicated the resident fell and did not have any apparent injuries. The primary care provider (PCP) was updated, and the resident was scheduled to be seen the following week. The day after the fall, the resident began to complain of increased knee pain. The facility failed to update the PCP about the increased pain. Facility staff documented that the resident was unable to bear weight and required two people to transfer. The nurse was updated on increased pain but was not informed of the resident's inability to bear weight and difficulty transferring. The next day, the resident reported to staff he had "excruciating pain, 10/10 pain" all over and nothing was helping. Facility staff reported the resident's complaint to the on-call nurse. The resident requested to go to the emergency room and was sent in shortly after.

Hospital records indicated the resident was diagnosed with compression fractures to his neck and a left femur (leg) fracture.

During an interview, the nurse stated the resident was normally able to walk independently with his walker and he could communicate his needs and indicate if he was in pain. The nurse stated the facility called the ambulance for him in the past and the resident refused to go in so if he requested to go in, they would send him in. The nurse stated facility staff updated her on the resident's pain and she entered a progress note shortly after, but they had not updated her on the change in his transfer status.

During investigative interviews, unlicensed personnel (ULP) stated the resident had increased complaints of pain after his fall. The ULP stated they had been giving the resident pain medications and pain-relieving cream when he had complaints of pain. One ULP stated she thought the nurse had been updated on the resident's change in transfer status but was not sure.

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: Unable due to cognition

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility reported the incident to MAARC.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30498	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/06/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER VERMILION SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1232 BIRCH STREET NORTH TOWER, MN 55790
--	---

(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	<p>Initial Comments</p> <p>On April 6, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL304989363M/#HL304983560C. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____