Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307791340M
Compliance #: HL307791941C

Date Concluded: May 9, 2025

Name, Address, and County of Licensee Investigated:
York Gardens of Edina
3451 Parklawn Ave
Edina, MN 55435
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
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 by failing to refill and administer his mental health medications. As a result, the resident missed 11 days of medication and was subsequently hospitalized following a fall.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Upon admission, the resident was prescribed donepezil and sertraline. At the time, the medications were not eligible for refill through the facility's pharmacy. A family member informed staff that she had both medications at home and would administer them daily until a refill could be processed. A review of the documentation and family member interview confirmed the resident did not miss any doses during this period.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included review of the resident's records, incident reports, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included assistance with medications.

A report indicated that the resident's medications, including donepezil and sertraline (both psychoactive medications), were placed on hold in the facility's system because they were not yet due for refill. According to the facility's medication administration records, the resident did not receive these medications for a period of 11 days.

During an interview, a healthcare worker stated the resident was admitted to the hospital following a fall. A pharmacy review of the resident's medication list found the resident had missed 11 days of donepezil and sertraline, as prescribed by the physician. The health care worker stated the abrupt discontinuation of donepezil may result in worsening cognitive function, altered mental status, hallucinations, delusions, insomnia, increased anxiety, and agitation. Similarly, sudden discontinuation of sertraline could lead to Antidepressant Discontinuation Syndrome (ADS), which presents with symptoms such as nausea, insomnia, fatigue, muscle aches, and dizziness.

During an interview, a nurse stated she informed the family member that two of the resident's medications were too early to refill and would not be available unless paid for out-of-pocket. The family member said that she had both medications at home. However, because the medications were in original prescription bottles, the facility's policy required a licensed nurse to complete a proper medication setup. The nurse reported the family member declined this service and instead chose to come in daily to administer the medications herself. The nurse added that, per facility policy, unlicensed caregivers were not permitted to administer medications directly from the bottle. The family member routinely stopped by the nurse's office and informed her she had administered the resident's medications.

During an interview, a family member stated that upon the resident's admission, the facility did not have the prescribed medications available. The family member stated she had remaining doses of the resident's donepezil and sertraline at home and continued to administer these medications daily until the facility obtained them. She confirmed the resident did not miss any doses. Once the facility received the medications, she was instructed to discontinue administration, and facility staff took over medication management of those medications.

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: No.
Family/Responsible Party interviewed: Yes.
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
	30779	A. BUILDING: _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK GARDENS SENIOR LIVING	3451 PARKLAWN AVENUE 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 On April 24, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL307791340M/HL307791941C. No correction orders are issued.	0 000		