Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307387982M
Compliance #: HL307388582C

Date Concluded: February 12, 2026

Name, Address, and County of Licensee Investigated:
Edgewood Virginia I Senior Living LLC
705 17th Street North
Virginia, MN, 55792
Saint Louis County

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

Evaluator's Name: Angela Vatalaro, 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 when the resident missed doses of her anti-psychotic medication. As a result, the resident's mental health declined requiring hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident's anti-psychotic medication required a 3 milligram (mg) to be given in conjunction with a 9 mg dose to total 12 mg, the facility made attempts to reorder the 3 mg dose. The medication was not available is a 12 mg dose form. The resident had a history of hallucinations and delusions. During the timeframe of the missed 3 mg doses, the resident's records did not indicate behaviors of delusions or hallucinations until the day the resident transferred to the emergency room for psychiatric evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff. The investigation included review of the resident records, pharmacy records, the

resident's medication re-order history, facility internal investigation, and related facility policy and procedures. Also, the investigator observed the facility and staff interactions with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included bipolar disorder, mania, anxiety, and paranoid schizophrenia. The resident's service plan included assistance with managing the resident's agitation, anxiety, and hallucinations. The resident received medication management and medication administration services. The resident's assessment indicated the resident hallucinated and would see or hear things that were not real.

The resident's medication administration record (MAR) and provider orders indicated an order for an anti-psychotic medication given daily. The order required the medication administration of a 3 mg dose and a 9 mg to equal a total of 12 mg for staff administration.

Progress notes indicated the resident had hallucinations when she moved her mattress to the adjourning room stating she felt safer because she had been seeing knives. Staff assisted the resident, placed the mattress back in the correct room, and assisted with room order.

The resident's MAR indicated the resident had received her 12 mg dose of antipsychotic thus far during the month and on the day of the hallucination incident.

A fax response from the resident's mental health provider regarding the resident's delusions indicated to schedule a follow-up appointment if the resident was having concerning delusions causing her distress or if she was at risk of losing her housing. The provider indicated unfortunately sometimes delusions were not able to be addressed with medications.

After that, the resident's MAR indicated the resident missed her 3 mg dose of her antipsychotic 12 times due to the medication was not available. During this timeframe, the resident received her 9 mg dose of the same antipsychotic.

The facility reorder history report indicated during this 12-day timeframe of the missed 3 mg doses; staff reordered the resident's 3 mg dose five times. The MAR also indicated staff reordered the medication and indicated this was "reordered several times."

The facility internal investigation and progress notes indicated the resident's mental health provider was contacted for refills without success.

During the timeframe when the resident did not receive her 3 mg anti-psychotic dose prior to the resident's emergency room transfer, the resident's behavior and service delivery records did not indicate behaviors of delusions or hallucinations until the day the resident transferred to the emergency room for psychiatric evaluation. Multiple entries during this timeframe regarding her behaviors included entries such as "no behaviors" "no concerns" "no anxiety" "good."

Progress notes indicated the day of the emergency room transfer, the resident reported to leadership that another identified resident came into her room over a weekend, laid on top of her, and the resident said she was “raped’ by the other resident. The resident also stated the other resident was never in-between her legs.

The facility’s internal investigation included pinpoint location and contact tracing reports of both the resident and the other resident the resident identified as being in her room. The reports indicated the other resident had not been in the resident’s room nor had contact with the resident.

Progress notes indicated a nurse assessed the resident. The resident’s primary care provider also saw the resident the day the resident reported this. The resident transferred to the emergency room.

Progress notes indicated the resident admitted to the hospital for a psychiatric evaluation. While hospitalized the resident’s psychosis continued. The notes indicated her psychosis was not worse however it was not better. The hospital adjusted her medications. During multiple facility updates there was no plan on discharge back to facility. At one point during one of the updates, the provider at the hospital felt the resident was not stable enough for discharge. While hospitalized the resident reported she did not want to return to the facility. The facility informed the hospital the resident was welcome to come back when stable. The resident was discharged from the hospital to a different facility.

During an interview, leadership staff, who was also a nurse, stated when the resident alleged another identified resident went into her room, laid on her, and raped her, the facility conducted an internal investigation. Leadership stated the allegation was unfounded. Each resident at the facility wore wrist bands. The wrist band identified pinpoint location of each resident, showed where they are in a room, which room they are in, and does contact tracing of resident contact with other residents. The facility was able to determine the other resident the resident identified as being in her room had not been in the resident’s room. The facility also determined that no other resident had been in the resident’s room, nor did the identified resident have any contact with the resident. A facility nurse assessed the resident and the resident’s primary provider also saw her who happened to be rounding that day. It was determined the resident was in a mental health crisis and was sent to the emergency room. Leadership said she reviewed the resident’s behaviors twice monthly. She said when the resident’s mental health was well managed on medications her delusions and hallucinations would be more joyful like she won the lottery, or she confided in Tinkerbell. Overall, the resident would be in good spirits. However, when the resident’s mental health was not well managed the resident’s delusions and hallucinations became scary such as the resident talking about shootings, stabbings, or like this incident. Leadership said the facility made efforts to refill the resident’s 3 mg anti-psychotic by reordering it from pharmacy, contacting pharmacy, and contacting the mental health provider who was the prescriber. The pharmacy was waiting on

orders from the provider. The resident's 3 mg anti-psychotic did eventually get filled and came to the facility however it was the day the resident transferred to the emergency room.

During an interview, a nurse said she recalled the facility had been waiting for some time for the resident's refill of her anti-psychotic from pharmacy. The nurse said they were waiting on orders from the prescriber. The nurse stated she reached out to the pharmacy and reached out to mental health provider to let them know they needed refill of the resident's anti-psychotic. The nurse said the resident had a history of delusions and hallucinations. At times the resident required reorientation back into reality.

During an interview, the resident's family member stated the resident had mental health diagnoses and a history of delusions and hallucinations. The day the resident reported she was raped; the resident was sent to the emergency room for psychiatric evaluation. The resident did not return to the facility after hospitalization.

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. Unable to reach, and no due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility attempted to reorder the resident's 3 mg dose of anti-psychotic medication. The facility conducted an internal investigation when the resident reported concerns, assessed the resident, and coordinated transfer to the emergency room for psychiatric evaluation.

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
	30738	A. BUILDING: _____ B. WING _____	C 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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 December 30, 2025, the Minnesota Department of Health initiated an investigation of complaint HL307388582C/HL307387982M and HL307389923C/HL307388383M. No correction orders are issued.	0 000		