Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294083842M
Compliance #: HL294087387C

Date Concluded: October 15, 2025

Name, Address, and County of Licensee Investigated:
Mendota Heights WP LLC
745 South Plaza Drive
Mendota Heights, MN 55120
Dakota County

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

Evaluator's Name: Kris Detsch, 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 a resident when they failed to administer medications as prescribed. As a result, the resident had a seizure and required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure the resident's anti-seizure medication (lacosamide) was available. As a result, the resident had seizures and required hospitalization. Additionally, unlicensed personnel (ULPs) erroneously documented they gave the resident this medication when there was not supply.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's medical provider. The investigation included review of the resident records, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related

facility policy and procedures. Also, the investigator toured the facility and observed medication administration, narcotic medication procedures, and documentation processes.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and seizures. The resident's service plan included assistance with dressing, grooming, toileting, housekeeping, meals, and medications. The resident's nursing assessment indicated she had memory loss and poor decision-making ability.

Physician records indicated the resident was supposed to take lacosamide 100 milligrams (mg) twice daily to prevent seizures.

Medication administration records (MAR) indicated three days prior to the resident's seizure, ULPs did not give lacosamide to the resident because the facility needed to order the medication. Multiple ULPs documented they did not administer the medication during these three days, however within the documentation system, errors occurred. One ULP documented they gave the medication, however in a different area of the MAR they also documented the medication was not available (the facility needed to re-order it). Although there were documentation inaccuracies, the documentation indicated the resident missed seven dosages of lacosamide prior to the seizure.

Progress notes indicated a ULP saw the resident "shaking" as she sat in a chair. The ULP "assumed" it was a seizure and called emergency services (911).

Hospital records indicated the resident had another seizure when she was in the emergency room (ER) and her oxygen levels decreased to 30% (normal oxygen levels are above 92%). The resident required supplemental oxygen, and anti-seizure medications including lacosamide. The resident stayed in the hospital for six days, then returned to the facility.

Pharmacy delivery records also indicated they sent lacosamide to the facility, after the resident went to the hospital, one day prior to her return.

Facility narcotic records indicated they did not enter lacosamide into the narcotic logbook until after the resident returned from the hospital. There were no records to indicate the facility placed lacosamide into the locked box prior to the resident's hospitalization.

During an interview, a nurse said the resident missed a couple of dosages of lacosamide prior to the seizure when the facility switched pharmacy companies. The nurse said the facility did not consider lacosamide a "controlled substance", so they did not keep the medication inside the separate compartment (locked box) within the medication cart. The nurse said the new pharmacy told them the medication was a controlled substance, so they needed to keep the medication inside the locked box. The nurse said the ULPs were not aware the medication was in the locked box, so they did not give the medication. The nurse said ULPs would have

documented in a separate book (narcotic log) if they removed any medications from the lock box to give to the resident.

During consultation with a pharmacist, he said the pharmacy provided medications to the facility monthly (commonly referred to as a “cycle fill” system). The pharmacist said during the changeover process between the pharmacy companies, the facility was supposed to use up the resident’s current supply of medications, then contact them if they needed any medications refilled prior to the delivery of the routine cycle fill medications. The pharmacist said he contacted the resident’s physician to obtain a prescription for the lacosamide so the pharmacy could send the medication to the facility for their routine cycle fill. The pharmacist said the facility never requested a refill for lacosamide. The pharmacist said they only delivered the lacosamide to the facility after the resident went to the hospital. The pharmacist said, this was the first time they delivered the medication to the facility.

During an interview, the resident’s physician said she was not aware the resident missed dosages of lacosamide. The resident’s physician said abruptly stopping this medication could cause breakthrough seizures.

During an interview, a family member said multiple facility staff members told him the resident missed dosages of the lacosamide because the facility nurse forgot to re-order it.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The facility did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. Attempted, but could not participate.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility sent the resident to the hospital when she showed signs of a seizure.

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
Dakota County Attorney
Mendota Heights City Attorney
Mendota Heights Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29408	A. BUILDING: _____ B. WING _____	C 09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WP LLC	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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: HL294087387C/HL294083842M On September 18, 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 32 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL294087387C/HL294083842M, tag identification 620, 1690, 1760, 2360.	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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	0 620		

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0 620	Continued From page 2 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comply with the requirements for reporting suspected maltreatment within 24 hours for one of one resident (R1) with record reviewed. The licensee failed to give R1 her scheduled anti-seizure medication (lacosamide) and she missed seven dosages. R1 had seizures and required hospitalization. The facility was aware of the incident but did not report the incident to the Minnesota Adult Abuse Reporting Agency (MAARC). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	0 620		

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0 620	Continued From page 3 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings Include: R1 admitted to the licensee for diagnoses including dementia, depression, and major neurocognitive disorder (mental health disorder). R1 had seizure activity on January 27, 2025, and physicians diagnosed her with seizures, and treated her with anti-seizure medications. R1's service plan dated September 18, 2025, indicated the licensee provided R1's medication management. R1's physician order sheet dated February 27, 2025, indicated R1 should take lacosamide (medication used to prevent seizures) as follows: lacosamide 100 milligrams (mg) tablet, take one tablet oral twice daily at 8:00 a.m. and 8:00 p.m. R1's medication administration record (MAR) dated April 1, 2025, through April 30, 2025, indicated unlicensed professional (ULP) did not give R1 the medication on the following dates and times: -April 14, 2025, at 8:00 a.m. and 8:00 p.m. -April 16, 2025, at 8:00 a.m. -April 17, 2025, at 8:00 a.m. ULP documentation on the MAR indicated the licensee needed to re-order the medication. MAR documentation contained inaccurate administration, as ULPs documented they gave the medication on April 16, 2025, at 8:00 p.m., however also wrote on the MAR the licensee needed to reorder the medication.	0 620		

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0 620	Continued From page 4 Progress notes dated April 17, 2025, at 9:04 a.m., indicated a ULP saw R1 "shaking in her chair." The notes indicated the ULP assumed it was a seizure and called emergency services (911). Hospital records dated April 17, 2025, through April 23, 2025, indicated R1 had an additional seizure while in the emergency room and her oxygen levels decreased to 30% (normal oxygen levels are greater than 92%). R1 required additional anti-seizure medications, in addition to lacosamide. The records indicated R1 remained in the hospital for six more days, then discharged back to the licensee. On September 22, 2025, at 2:10 p.m., registered nurse (RN)-C said she was not at the licensee during R1's seizure, however she was aware of the incident. RN-C said R1 returned to the licensee after the hospital stay which was six days later. RN-C said she determined the lacosamide medication was in the locked compartment of medication cart, and staff were unaware the medication was there. RN-C said the licensee did not complete an incident report, or further documentation regarding the medication discrepancy, but her reason for this was unclear. RN-C said she did not remember any further communication with the hospital, or physician from the licensee to inform them of the disruption with R1's lacosamide administration. The licensee lacked evidence they placed R1's lacosamide into the locked medication compartment until April 23, 2023, upon her return form the hospital. This indicated, the licensee staff failed to administer seven dosages of lacosamide to R1 prior to her seizures on April	0 620		

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0 620	Continued From page 5 17, 2025. The licensee failed to submit a MAARC report. The licensee's policy titled, Vulnerable Adult Maltreatment-Prevention and Reporting, dated April 1, 2025, indicated the licensee would investigate an incident of suspected maltreatment. The policy indicated, if the licensee confirmed the maltreatment, they would contact the Minnesota Adult Abuse Reporting Center (MAARC) no later than 24 hours after the maltreatment was first reported. Time Period for Correction: Seven (7) days	0 620		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication	01690		

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01690	Continued From page 6 errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure their medication policy and practice regarding controlled substances followed state and federal regulations for one of one resident (R1) with record reviewed with a prescribed controlled substance. This deficient practice had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). The findings include: R1 admitted to the licensee for diagnoses including dementia, depression, and major neurocognitive disorder (mental health disorder).	01690		

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01690	Continued From page 7 R1 had seizure activity on January 27, 2025, and physicians diagnosed her with seizures, and treated her with anti-seizure medications. R1's service plan dated September 18, 2025, indicated the licensee provided R1's medication management. R1's physician order sheet dated February 27, 2025, indicated R1 should take lacosamide (medication used to prevent seizures) as follows: lacosamide 100 milligrams (mg) tablet, take one tablet orally (by mouth) twice daily at 8:00 a.m. and 8:00 p.m. R1's medication administration record (MAR) dated April 1, 2025, through April 30, 2025, indicated unlicensed professional (ULP) administered lacosamide April 1 through April 13, 2025. Pharmacy delivery records dated April 22, 2025, at 2:24 p.m. indicated the licensee received R1's supply of lacosamide (56 tablets). The licensee's narcotic record (book) indicated on April 23, 2025, the licensee received 56 tablets of lacosamide. The licensee documented in the book, they gave R1's first tablet on April 23, 2025, at 7:47 p.m., so 55 tablets remained. The licensee's narcotic book lacked indication they entered lacosamide into the book prior to April 23, 2025. On September 18, 2025, at 4:12 p.m., pharmacist (PH)-D said on April 7, 2025, their pharmacy started providing services to the licensee. PH-D said the pharmacy provided medications to the licensee monthly (commonly	01690		

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01690	Continued From page 8 referred to as a "cycle fill" system). PH-D said during the changeover process between the pharmacy companies, the licensee was supposed to use up the resident's current supply of medications, then contact them if they needed any medications refilled prior to the delivery of the routine cycle fill medications. PH-D said he contacted R1's physician (P)-A to obtain a prescription for the lacosamide so the pharmacy could send the medication to the licensee for their routine cycle fill. PH-D said the pharmacy received the prescription from P-A on April 11, 2025, so they could have supplied the licensee with the medication if they needed it. PH-D said the licensee never requested a refill for lacosamide. PH-D said they only delivered lacosamide to the licensee on April 22, 2025. PH-D said this was the first time their pharmacy delivered the medication to the licensee. (This was after R1 had seizure and went to the hospital, and one day prior to her return.) On September 19, 2025, at 10:39 a.m., licensed assisted living director (LALD)-E sent surveyor an email indicating the licensee used a different pharmacy prior to April of 2025, and the pharmacy did not consider lacosamide a narcotic, so the licensee did not count, or double lock the medication. LALD-E indicated after April 2025, the licensee's pharmacy then considered the lacosamide a schedule five controlled substance and recommended the licensee store the medication in a double locked cabinet in accordance with protocol for controlled substances. On September 22, 2025, at 2:10 p.m., registered nurse (RN)-C said she was not at the licensee during R1's seizure, however she was aware of	01690		

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01690	Continued From page 9 the incident. RN-C said R1 returned to the licensee after the hospital stay which was six days later. RN-C said she determined the lacosamide medication was in the locked compartment of medication cart, and staff were unaware the medication was there, so they did not administer it. RN-C said the licensee transitioned to a different pharmacy who required the medication to be in the locked compartment of the medication cart, which it had not been previously. RN-C said the licensee placed the lacosamide into the locked compartment, but was not aware "who" placed the medication there. RN-C said staff would then have documented the removal of the medication from the locked compartment in the narcotic logbook. RN-C said the licensee was going to remove the lacosamide from the locked box, per their policy, and place it in the general medication supply, as they did previously prior to the new pharmacy taking over. The Controlled Substance Act, located at https://www.dea.gov/drug-information/csa, indicated through federal law, controlled substances were listed in five classifications based upon medical use, potential for abuse, and safety. The Controlled Substance Act listed Vimpat (lacosamide) as a controlled substance, level five. The licensee's policy titled, Medication Storage, dated April 1, 2025, indicated medications will be stored by the facility to prevent diversion and securely locked in a medication room or medication cart. The policy inaccurately directed "optional but suggested to protect staff and minimize diversion" to secure schedule II (two) drugs under a double lock system and drug counts at the beginning and end of every shift.	01690		

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(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
01690	Continued From page 10 The policy lacked directive it is required and not optional to have a double lock system to store all controlled substances, drug class levels I through V. Minnesota Rules 6800.7800 indicates drug storage on nursing service units shall have a container or compartment that is capable of securing controlled substances with a lock or other safeguard system and shall be permanently attached to the storage cart or medication room. Federal Code Regulation CFR Title 21, Chapter II, Part 1301.72, indicates schedule I and II controlled substances shall be stored in a safe or secure cabinet if less than 750 pounds that is bolted or cemented to the floor or wall so that it cannot be readily removed or stored in a safe or steel cabinet equivalent to 30 man-minutes against surreptitious entry, 10 man-minutes against forced entry, 20 man-hours against lock manipulation and 20 man-hours against radiological techniques. Schedule III, IV and V controlled substances shall be stored in a safe or steel cabinet the same as for schedule I and II or a vault with an alarm system or a building with perimeter security, alarm system and self-locking material, or immobile, set in concrete steel cage. TIME PERIOD OF CORRECTION: Seven (7) Days	01690		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760		

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01760	Continued From page 11 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure lacosamide (a medication used to prevent seizures) was readily available for staff to administer as the physician ordered for one of one resident (R1) with record reviewed. As a result of this deficient practice, R1 did not receive seven dosages of lacosamide and had a seizure. R1 required hospitalization and had an additional seizure in the emergency room (ER). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee for diagnoses including dementia, depression, and major neurocognitive disorder (mental health disorder).	01760		

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01760	Continued From page 12 R1 had seizure activity on January 27, 2025, and physicians diagnosed her with seizures, and treated her with anti-seizure medications. R1's service plan dated September 18, 2025, indicated the licensee provided R1's medication management. R1's physician order sheet dated February 27, 2025, indicated R1 should take lacosamide (medication used to prevent seizures) as follows: lacosamide 100 milligrams (mg) tablet, take one tablet orally (by mouth) twice daily at 8:00 a.m. and 8:00 p.m. R1's medication administration record (MAR) dated April 1, 2025, through April 30, 2025, indicated unlicensed professional (ULP) did not give R1 the medication on the following dates and times: -April 14, 2025, at 8:00 a.m. and 8:00 p.m. -April 16, 2025, at 8:00 a.m. -April 17, 2025, at 8:00 a.m. ULP documentation on the MAR indicated the licensee needed to re-order the medication. MAR documentation contained inaccurate administration, ULP's documented they gave the medication on April 15, 2025, but then on April 16, 2005, the medication was not available for the 8:00 a.m. administration. On April 16, 2025, at 8:00 p.m. a ULPs documented they gave the medication, however, also wrote on the MAR the licensee needed to reorder the medication. There was no evidence the licensee had the medication to administer from April 14, 2025, through April 17, 2025. Progress notes dated April 17, 2025, at 9:04	01760		

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01760	Continued From page 13 a.m., indicated a ULP saw R1 "shaking in her chair." The notes indicated the ULP "assumed" it was a seizure and called emergency services (911). Hospital records dated April 17, 2025, through April 23, 2025, indicated R1 had an additional seizure while in the emergency room and her oxygen levels decreased to 30% (normal oxygen levels are greater than 92%). The records indicated R1 had an elevated lactate blood level which indicated she had a seizure. R1 required additional anti-seizure medications, in addition to lacosamide. The hospital records indicated physicians were unaware there was a disruption in R1's lacosamide administration. The documentation read as follows, "She returns today with breakthrough seizure activity. She should have gotten a dose of Vimpat (lacosamide) at her care center this AM, then received another dose in the ER." The records indicated R1 remained in the hospital for six more days, then discharged back to the licensee. Pharmacy delivery records dated April 22, 2025, at 2:24 p.m. indicated the licensee received R1's supply of lacosamide (56 tablets). The licensee's narcotic record (book) indicated on April 23, 2025, the licensee received 56 tablets of lacosamide. The licensee documented in the book, they gave R1's first tablet on April 23, 2025, at 7:47 p.m. so 55 tablets remained. The licensee's narcotic book lacked indication they entered lacosamide into the book prior to April 23, 2025. On September 18, 2025, at 4:12 p.m., pharmacist (PH)-D said on April 7, 2025, their	01760		

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01760	Continued From page 14 pharmacy started providing services to the licensee. PH-D said the pharmacy provided medications to the licensee monthly (commonly referred to as a "cycle fill" system). PH-D said during the changeover process between the pharmacy companies, the licensee was supposed to use up the resident's current supply of medications, then contact them if they needed any medications refilled prior to the delivery of the routine cycle fill medications. PH-D said he contacted R1's physician (P)-A to obtain a prescription for the lacosamide so the pharmacy could send the medication to the licensee for their routine cycle fill. PH-D said the pharmacy received the prescription from P-A on April 11, 2025, so they could have supplied the licensee with the medication if they needed it. PH-D said the licensee never requested a refill for lacosamide. PH-D said they only delivered lacosamide to the licensee on April 22, 2025. PH-D said this was the first time their pharmacy delivered the medication to the licensee. (This was after R1 had seizure and went to the hospital, and one day prior to her return.) On September 22, 2025, at 9:19 a.m., P-A said the pharmacy sent her a request for R1's lacosamide on April 10, 2025. P-A said the electronic prescription was effective on April 11, 2025, and received by the pharmacy. P-A said the licensee did not contact her regarding R1's lacosamide, only the pharmacy. P-A said R1 required lacosamide because she had a history of seizures. P-A said R1 had an additional seizure while she was in the ER and required additional anti-seizure medications. P-A said the licensee did not contact her regarding any disruption of R1's lacosamide administration. P-A said she was unaware R1 missed dosages, and	01760		

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01760	Continued From page 15 said it was concerning because the medication was for preventing seizures. P-A said abruptly stopping this medication would cause R1 to be at a high risk for seizures. On September 22, 2025, at 2:10 p.m., registered nurse (RN)-C said she was not at the licensee during R1's seizure, however she was aware of the incident. RN-C said R1 returned to the licensee after the hospital stay which was six days later. RN-C said she determined the lacosamide medication was in the locked compartment of medication cart, and staff were unaware the medication was there, so they did not administer it. RN-C said the licensee did not complete an incident report, or further documentation regarding the medication discrepancy, but her reason for this was unclear. RN-C said she did not remember any further communication with the hospital, or physician from the licensee to inform them of the disruption with R1's lacosamide administration. The licensee's policy titled, Medication and Supplies-Reordering, dated April 1, 2025, indicated the licensee's nursing staff would re-order medications from the pharmacy, and reconcile the medications when they arrived. The licensee would make sure medications and supplies were available as needed. The policy also indicated the licensee would store schedule two the medications to prevent diversion in a separate, double locked system, separately from other medications, and count these medications. The policy failed to indicate how the licensee would store all controlled substances. Time period for correction: Seven (7) days.	01760		

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02360	Continued From page 16	02360		
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 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was 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 report for details.	02360		