

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304153122M
Compliance #: HL304155667C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee

Investigated:

New Perspective Waconia
500 South Cherry Street
Waconia, MN 55367
Carver County

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

Evaluator's Name: Brandon Martfeld, RN,
BSN, 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 the resident's seizure medication was incorrectly discontinued resulting in a seizure and hospitalization.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. Although one of the resident's anti-seizure medications was incorrectly discontinued, it could not be determined whether the medication error caused the resident to have a seizure. The resident was prescribed multiple anti-seizure medications and adjustments were made to those medications during the time frame. One month after the medication error, the resident experienced an uncontrolled seizure that required an evaluation at a hospital.

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 records, hospital records, facility internal

investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included generalized idiopathic (unknown cause) epilepsy (seizures) and Alzheimer's disease. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident was cognitively alert and had a history of seizures.

Review of the resident's medical record indicated on admission to the facility, the resident's anti-seizure medications included Depakote (medication used to treat seizures) 250 milligrams (mg) take 2 tablets twice a day, Lacosamide (medication used to control and prevent seizures) 100 mg one-half tablet twice a day, Lamotrigine (used to treat several conditions, mainly epilepsy and bipolar disorder) 150 mg, one tablet twice a day, and Keppra (used to treat seizures) 1000 mg one tablet twice a day. The medical record indicated on admission to the facility, the resident's medical provider increased the resident's dose of Keppra and discontinued Lacosamide. However, in the days following the Lacosamide being discontinued, facility staff also discontinued Lamotrigine.

The facility's internal investigation indicated the resident began having seizures one day. The resident was transported to the hospital. The facility investigation indicated a medication error occurred when an anti-seizure medication (Lamotrigine) was discontinued.

Hospital records indicated the resident was admitted to the hospital for seizures. During the resident's hospitalization, it was determined when the resident resided at the assisted living, the resident's lamotrigine had been discontinued in error approximately one month prior to the hospital admission. The hospital records further indicated the resident had a longstanding history of a seizure disorder. A neurologist (a medical doctor who specializes in diagnosing, treating, and managing disorders of the brain and nervous system) made attempts to change the resident's anti-seizure medications for better control of the resident's seizures prior to the hospitalization.

During an interview, a nurse stated the resident was on multiple anti-seizure medications. Approximately one month prior to the resident being hospitalized, one of the resident's anti-seizure medications (Lamotrigine) was "accidentally" discontinued. The nurse stated after the incident, the facility educated staff on medication administration, refills and policies and procedures for medication orders. A competency evaluation was completed for all staff on starting and discontinuing medication orders.

During an interview, leadership stated the resident had a history of seizures. At admission to the facility, the resident's medications were being adjusted and a nurse "inadvertently" discontinued one of the resident's anti-seizure medications (Lamotrigine). The procedure for discontinuing medications had been changed and education for the nurse had been completed. Facility wide audits were completed to ensure medications were discontinued appropriately.

During an interview, the primary care provider stated the resident had a complicated health history and required multiple medications for seizures. When the resident was admitted to the facility approximately one month prior to the hospitalization, the resident's neurologist was actively adjusting the resident's anti-seizure medication. The resident had a seizure approximately three weeks prior to admitting into the facility. The primary provider stated it would be difficult to determine if the anti-seizure medication being discontinued caused the resident's seizures and hospitalization.

An attempt to interview the resident's neurologist was unsuccessful.

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: Yes.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

When the resident began having seizures, the facility transferred the resident to the hospital. The facility provided education to the nurse, completed audits of medications that were discontinued and changed the procedure when discontinuing medications with the pharmacy.

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: 30415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/25/2025
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NAME OF PROVIDER OR SUPPLIER NEW PERSPECTIVE WACONIA	STREET ADDRESS, CITY, STATE, ZIP CODE 500 CHERRY STREET WACONIA, MN 55387
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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
0 000	<p>Initial Comments</p> <p>On June 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304153122M/#HL304155667C. No correction orders are issued.</p>	0 000		

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