Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318563142M
Compliance #: HL318565887C

Date Concluded: October 31, 2025

Name, Address, and County of Licensee Investigated:
Minnetonka Care Residence
421 Spring Valley Drive
Bloomington, Minnesota 55420
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 the facility ran out of her medication. The resident experienced several seizures and was hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. An alleged perpetrator (AP) was identified during the investigation. The facility was not responsible for maltreatment. The AP, a nurse, was responsible for ordering medications. The AP stated she spoke with the pharmacy who then delivered the resident's medication too late. It was unclear how far in advance the AP requested a refill of the resident's medications. The resident missed a dose of medication, had a seizure, and went to the hospital. After hospitalization, the resident returned to her baseline condition.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator contacted family, the provider, and social worker. The

investigation included review of the resident records, clinic records, hospital records, pharmacy records, personnel files, staff schedules, law enforcement report, related facility policy and procedures. Also, the investigator observed medication administration and resident medications.

The resident resided in an assisted living facility. The resident's diagnoses included seizures. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident needed medication management.

An ambulatory run report indicated emergency medical services (EMS) arrived at the facility after receiving a report of the resident seizing for 15 minutes. Facility staff reported they went to look for the resident after not seeing her for two hours. Staff found the resident in her bed, unresponsive but breathing, foaming at the mouth, and drooling. Staff reported the resident's prescribed medications ran out the day before, so she had not had any of her seizure medications for one day. EMS found the resident lying in her bed, profusely sweating, her skin flushed and hot to touch. EMS transported the resident to the emergency department (ED).

A second ambulatory run report the next day indicated EMS found the resident seized for several while being transported the resident back to the facility from the hospital. The resident appeared alert and communicated easily but did have a slightly low oxygen level. EMS brought the resident into the ambulance where she began seizing again. EMS transported the resident back to the ED.

The resident's hospital record indicated the resident missed one dose before seizing. The resident's seizure activity had been attributed to running out of levetiracetam (an anticonvulsant medication used to treat seizures) which had been requested on time but had been delivered late. The resident received levetiracetam, stayed overnight in the ED, then discharged back to the facility. However, the resident seized on the drive back to the facility, so she returned to the ED. The hospital admitted the resident and diagnosed her with seizure activity with aspiration pneumonia (an infection of the lungs). The resident received antibiotics for pneumonia. The discharge summary indicated hospital staff did not see a pattern of poor care provided by the facility. The resident reported being at her baseline at discharge, though physical therapy (PT) noted she had some deconditioning from her hospitalization. The resident discharged after being admitted for about 10 days and transferred back to the facility.

The resident's medication administration record indicated the resident missed two seizure medications in the morning and at noon the day of the incident. The resident did, however, receive her third seizure medication in the morning as scheduled.

Pharmacy records indicated the facility received the resident's medications about an hour after she left for the hospital.

An email to the AP from the pharmacy two days after the incident indicated the pharmacy discussed the medication fill cycle process and the importance of the facility making sure they have enough medication to get through to the beginning of the next cycle. They also provided a form for the facility to report missing medications and request additional doses.

During an interview, an unlicensed personnel (ULP) stated she did not remember the prior shift staff or the resident say anything about being out of her medications. She checked on the resident in between preparing dinner. The resident wanted to lie down a little longer before coming upstairs for the meal. The ULP went back upstairs, finished preparing dinner, and began serving the other residents. Because the resident did not come up for dinner, the ULP went downstairs to look for her. The ULP called for the resident, but the resident did not answer. The ULP went into the resident's room and found the resident seizing on the bed, foaming at the mouth. The ULP called 911 and the nurse, and the resident went to the hospital. The ULP stated the resident may have been seizing for about 30 minutes.

During an interview, the resident's provider stated the resident's seizures were well controlled in general, although she did have a history of breakthrough seizures while on several medications. The resident could have seizures that were very prolonged, or one after another. These at times required ventilator care in intensive care units (ICU). The provider described the resident as a high risk for seizure activity if she missed medications. The provider stated the seizure activity had likely been caused by missing her medication. The provider did not identify any long-term injuries from the resident's seizure activity.

During an interview, the AP stated the pharmacy was going to deliver the resident's medications, but there had been an issue, and the shipment got delayed. The AP stated the pharmacy told her they would deliver the resident's medications early the next day. That next day, the evening of the incident, the AP stated a ULP called and informed her the pharmacy had not yet delivered the medications, so the resident did not receive her scheduled medications. A short time later, the AP received another call from a ULP informing her the resident had been seizing. The resident transferred to the hospital and stayed there about nine days due to developing pneumonia. Since returning from the hospital, the resident had not had any other seizure activity while at the facility and returned to her baseline condition.

During an interview, the resident stated the facility would not call the pharmacy to deliver her medication, so she missed taking some. The resident stated she had a seizure and developed pneumonia and sepsis (an infection in the bloodstream). The resident stated a staff member found her and called 911.

During an interview, a family member stated the resident had been seizure-free for six years prior to this incident. The resident developed pneumonia and sepsis. Since the incident, the resident had been more forgetful and disoriented at times.

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: Yes.

Action taken by facility:
The facility sent the resident to the hospital.

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
	31856	A. BUILDING: _____ B. WING _____	C 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNETONKA CARE RESIDENCE	421 SPRING VALLEY DRIVE BLOOMINGTON, MN 55420

(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 September 3, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL318565887C/#HL318563142M. No correction orders are issued.	0 000		