Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL200744182M
Compliance #: HL200748049C

Date Concluded: October 30, 2025

Name, Address, and County of Licensee Investigated:
Centennial Villa
Annandale Care Center
660 Park St E
Annandale, MN 55302
Wright County

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

Evaluator's Name: Brooke Anderson, 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 the resident when the resident did not receive his seizure medication resulting in 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 have a process in place to ensure the resident would receive medications ordered by the physician. The resident admitted to the facility and when medications were not delivered by the pharmacy the resident did not receive four doses of his levetiracetam and carbamazepine (anti-seizure medications) resulting in a grand mal seizure (a type of generalized seizure that causes sudden loss of consciousness and involuntary muscle contractions) and hospitalization. The resident was admitted to the intensive care unit and was discharged to a higher level of care.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included seizure disorder and memory loss. The resident's service plan included assistance with showers and medication management. The resident's assessment indicated the resident's medications were to be locked in the medication cart for facility staff to administer.

The internal investigation indicated the resident had moved into the facility on a Friday. A facility nurse assessed the resident and ordered his medications to be prepackaged in bubble cards to be delivered that night. A facility nurse advised family to leave some bottled medications in the resident's apartment in case the medications were not delivered by the pharmacy. Facility staff were verbally advised to use the bottled medications if the prepackaged bubble cards were not delivered.

The medication administration record indicated the resident was to receive carbamazepine 200 milligram one tablet twice a day and levetiracetam 750 milligrams two tablets twice a day. The resident did not receive four doses of both medications. The medication administration record indicated the medications were not administered because the drug was not available. The medication administration record did not indicate where the medications were stored.

A progress note indicated five days after the resident admitted to the facility a facility staff entered the resident's room and found him lying in his bed on his right side, secretions coming from his mouth, hands contracted, and he was convulsing. A facility staff called a facility nurse who assessed the resident, 911 was notified, and the resident was sent to the emergency department.

Hospital records indicated the resident arrived at the hospital confused following seven seizure events, one described as a grand mal seizure. The hospital records indicated the resident had missed multiple doses of his antiepileptic medications. The resident was transferred to neurology intensive care unit in a different hospital. After approximately seven days in the hospital the resident was discharged to a higher level of care.

During investigative interviews, multiple staff members stated the resident did not receive all of seizure medications while he lived at the facility. His seizure medications were in bottles placed under the sink, but their location was not communicated to all staff. A staff member stated once emergency medical services arrived a facility nurse grabbed the medication bottles from below the sink and placed them in the medication cart.

During an interview, the facility nurse stated the facility staff were instructed to use the medications in bottles if the pharmacy did not deliver the prepackaged bubble cards. The communication fell through, and not all staff knew the bottled medications were in the resident's room. The facility nurse stated during the time the resident was living at the facility no staff reported the resident's medications were missing and no follow up was completed by nursing to ensure medications were delivered as ordered. The resident went without doses of his seizure medication resulting in hospitalization. After the incident the facility conducted facility wide education, updated policies, and implemented audits to prevent reoccurrence.

During an interview, a family member stated the day the resident admitted she was advised to leave the bottled medications in the resident's closet just in case the pharmacy did not deliver the prepackaged bubble cards. A family member stated the resident was hospitalized and needed a higher level of care after the incident.

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.

Vulnerable Adult interviewed: No, vulnerable adult had since moved out of facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff called 911 when the resident was found having 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20074	A. BUILDING: _____ B. WING _____	C 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVING	600 PARK STREET EAST ANNANDALE, MN 55302

(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: #HL200748049C/#HL200744182M On September 11, 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 107 residents receiving services under the provider ' s Assisted Living license. The following correction order is issued/orders are issued for #L200748049C/#HL200744182M, tag identification 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20074	A. BUILDING: _____ B. WING _____	C 09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVING	600 PARK STREET EAST ANNANDALE, MN 55302

(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
02360	Continued From page 1	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(s) 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		