Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302311545M
Compliance #: HL302312454C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee Investigated:
Cedar Court
810 West Main Street
Adams, MN 55909
Mower County

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

Evaluator's Name: Brooke Anderson, 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 resident used a lighter to ignite a cigarette and caught his clothes on fire.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to incomplete and conflicting accounts of the incident, it could not be determined if maltreatment occurred.

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 incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included muscular dystrophy. The resident's care plan included assistance with dressing, grooming,

behavior management, and supervision of lighter use. The resident's assessment indicated the resident was alert with no cognitive impairment. The resident refused assistance with smoking.

Documentation indicated the resident used a lighter to light a cigarette outside when he caught his hooded sweatshirt on fire. The resident needed assistance to smother the fire to protect himself.

The resident's medical record indicated the resident caught his clothes on fire, the medical provider was updated, and the resident was ordered to not use a lighter without supervision.

During an interview, a staff member stated the resident was outside smoking and when a staff member let the resident inside, staff noted a burn spot on the hood of the resident's sweatshirt. A staff member stated facility management was notified and advised to increase monitoring of the resident however his care plan was not updated and increased monitoring was not done.

During an interview the facility nurse stated the resident was not compliant with the facility rules and refused staff supervision and would leave the facility if staff tried to supervise him. The facility nurse stated she was not sure when the incident occurred. The laundry staff reported the burn in the hooded sweatshirt, and she interviewed staff, but no staff knew what happened. The facility nurse stated the resident's care plan included a behavior section, but that section did not indicate specific smoking instructions for staff. A facility nurse stated staff were educated on resident smoking concerns however stated the education was not documented.

During an interview, the resident stated the facility had attempted interventions, but the staff had other residents to care for and they did not need to watch him smoke. The resident stated the incident was a small incident and he did not get burned.

During an interview, an outside agency staff member involved in the resident's care stated the resident had two incidents with smoking, one included his hooded sweatshirt getting burnt and one when he burnt his hand. An outside agency staff member stated the facility had guidelines in place for the resident including to not smoke in the facility and locking up lighters in the medication cart but she was not aware of additional interventions put in place to prevent reoccurrence.

During an interview, the resident's responsible party stated when the resident's hood was smoldering the resident tapped the smoldering out. The responsible party stated the facility had to give him the lighter and knew when he would go outside to smoke. The responsible party did not believe the resident would refuse supervision while he smoked.

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:
The facility updated the provider regarding the incident.

Action taken by the Minnesota Department of Health:
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
	30231	A. BUILDING: _____ B. WING _____	C 05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COURT	810 WEST MAIN STREET ADAMS, MN 55909

(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: #HL302312454C/#HL302311545M On May 14, 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 47 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for ##HL302312454C/#HL302311545M, tag identification 2310.	0 000		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310		

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02310	Continued From page 1 standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure appropriate care and services were provided for two of two residents (R1 and R2) who were reviewed for safe smoking. The licensee failed to assess and implement interventions following incidents of unsafe smoking. This had the potential to affect all the residents, staff, and visitors of the facility. 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 and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 Review of R1's medical record indicated R1's diagnoses included muscular dystrophy and traumatic brain injury. R1's medical record indicated R1 used oxygen at one liter using a nasal cannula for comfort while resting in his bed or recliner. R1's progress note dated January 9, 2025, indicated R1's room smelt of smoke and marijuana. R1 was educated on the risk of smoking and having an open flame in the presence of oxygen. R1 was reminded when he left the hospital that he had signed an agreement	02310	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	

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02310	Continued From page 2 that R1 would not have an open flame in his room near oxygen. R1's service check off for February 2025 indicated R1's behavior interventions included supervision of use of a lighter, and to document refusal of allowing staff to supervise R1 using the lighter. R1's smoking assessment dated March 25, 2025, indicated R1 was safe to smoke with staff supervision but refused assistance from staff and that R1 was to be safe while smoking. A progress notes dated March 31, 2025, indicated R1 caught his clothes on fire. R1 was directed to not use a lighter without supervision. R1's record lacked evidence smoking interventions were put in place after the incident to prevent reoccurrence and protect R1's health and safety or safety of residents and staff in the building. A physician's order dated April 4, 2025, indicated R1 had a burn to his thumb; cleanse and apply bacitracin and band aid daily until healed. R1's record lacked evidence smoking interventions were put in place after the incident to prevent reoccurrence. R2 Review of R2's medical record indicated R2's diagnoses included suicidal ideation and spastic hemiplegia. R2's medical record indicated that R2 smoked 20-30 cigarettes a day. R2's incident reported dated fall 2024 indicated R2 was outside in the smoking area and was	02310	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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02310	Continued From page 3 raking up leaves on the patio. R2 reported it was windy and R2 shielded his face with his coat while he was smoking. The cigarette fell into R2's coat and he used his garden glove and patted the fire out with his hand. R2 stated it happened a second time and that he threw the jacked away because of the burns. R2's incident report indicated facility staff were not aware the incident occurred. The incident report indicated R2 continued to smoke 20-30 cigarettes daily outdoors. R2's record lacked evidence smoking interventions were put in place after the incident to prevent reoccurrence and protect R2's health and safety or safety of residents and staff in the building. During an observation on May 14, 2025, 12:07 p.m., R2 was seen outside the front of the facility smoking a cigarette with multiple packs of cigarettes on the wheelchair table. R2 was seen putting the cigarette out on the wooden bench near him while painting boulders. R2's sweatpants were observed to have burn holes. During an interview on May 14, 2025, at 1:09 p.m., unlicensed personnel (ULP)-D stated staff managed R1's and R2's cigarettes and lighters. ULP-D stated she did not go outside to supervise R1 and R2 because she did not want to smell like smoke. ULP-D stated R1 did not make the best choices. ULP-D stated no new interventions were in place to ensure R1 and R2 smoked safely. During an interview on May 22, 2025, at 10:00 a.m. ULP-C stated the only training she received on residents smoking was about the location where they could smoke and that residents have the right to smoke. ULP-C stated staff let	02310		

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02310	Continued From page 4 residents outside to smoke and R1's lighter is locked in the medication cart. ULP-C stated no residents were monitored while they smoked even though incidents have occurred with fires and burns. ULP-C stated staff do not have time to watch residents smoke. ULP-C stated there are residents that should be monitored while smoking for their safety. ULP-C stated after R1 burned his hooded sweatshirt facility management advised to increase monitoring however his care plan was not updated and increased monitoring was not done. During an interview on May 20, 2025, at 3:00 p.m. Registered nurse (RN)-A stated the residents have rights and the facility cannot tell them what to do. RN-A stated resident care plans included a behavior section, but it did not indicate specific smoking instructions for staff. RN-A stated staff had been educated on residents and smoking concerns however stated the education was not documented. RN-A stated after R1 started his hood on fire, she obtained an order from the provider to put his lighters in the medication cart and that the facility was already using this intervention but now an order was obtained. RN-A stated R1 had no additional interventions implemented. During an interview May 14, 2025, at 11:15 a.m. Licensed assisted living director (LALD)-E stated the residents have rights, so it makes it hard for the facility to implement rules and policies. The licensee's smoking/e-cigarettes policy dated December 30, 2024, indicated residents that smoke will be assessed for smoking safety. No additional information was provided.	02310		