

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302316163M
Compliance #: HL302314621C

Date Concluded: November 3, 2025

Name, Address, and County of Licensee

Investigated:

Cedar Court Assisted Living and Memory Care
810 West Main Street
Adams, MN 55909
Mower County

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

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) abused the resident when she rough handled the mechanical lift sling while she transferred him causing him to cry out in pain from pinching and causing the resident to use foul language. After she completed the transfer, the AP withheld the resident's oxygen and threw his personal items of his around his room. As a result, the resident suffered physical pain and emotional distress.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP failed to remove the resident's mechanical lift sling properly causing the sling to pinch the resident and he experienced scrotal pain. The AP refused to give the resident his oxygen and blanket after the transfer occurred; then pushed the resident's table which caused items to go onto the floor, and across the room. The AP then left the resident. Photo images of the resident's room also showed multiple items scattered around. The resident suffered physical pain and emotional distress as a result.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility observed mechanical lift transfers, medication administration, wound care, staffing levels, and documentation processes.

The resident resided in an assisted living memory care unit. The resident's diagnoses included myotonic muscular dystrophy (muscle weakness, and stiffness). The resident's service plan included assistance with bathing, dressing, grooming, toileting, medication management, and mobility. The resident's nursing assessment indicated he was unable to walk and required a mechanical lift (Hoyer) with assistance of two staff members to transfer and an electric wheelchair for mobility. The assessment indicated the resident's behavior included using profanity. The resident received hospice care (end of life). The resident wore oxygen at bedtime.

The facility's internal investigation indicated unlicensed personnel (ULP) #1 helped the AP with the resident's mechanical lift transfer. ULP #1 reported they toileted the resident and then transferred him to his recliner when she left the room to return assisting her resident. ULP #2 saw the AP come out of the resident's room 10 minutes after ULP #1 left and the AP slammed the door as she walked outside. The resident then put on his call light and ULP #2 answered. ULP #2 reported there was cups and water on the floor and the resident's side table items were also on the floor. ULP #2 said the resident was distressed, his blanket was on the floor where he could not reach it. ULP #2 said the resident reported the AP was rough, pushed all of his tray table items to the floor, refused to give him his blanket and oxygen cannula, and the AP walked out of the room. ULP #2 said the resident said he never wanted the AP to come near him [again]. ULP #1 said she learned after she left, the AP pulled the sling underneath the resident too hard, and it upset the resident. Nurse interviewed the resident, who reported the AP was forceful and rough while using the sling. He asked the AP to stop and she did not. He cried out in pain when the sling pinched his scrotum and he then swore at the AP. The resident reported the AP got angry, put the resident's oxygen tubing out of reach and threw the resident's blankets and belongings. The AP was suspended.

Photo images of the resident's room showed a water cup on the floor, across from the resident, just inside the entrance from his room. Another photo showed a cup on the windowsill, behind the resident, tipped over, with water on the windowsill. There were personal items on the floor under the window such as small pink basket, paper, and a Kleenex box (behind the resident, out of his reach).

During an interview, ULP #1 said she helped the AP transfer the resident out of his wheelchair, to the commode, then into his reclining lounge chair. ULP #1 said the resident slept in his reclining lounge chair during the night. ULP #1 said, after she helped get the resident into the

reclining chair, she left the room. ULP #1 said the AP was in the process of removing the sling from under the resident and his room was in order when she left. ULP #1 said everything seemed "OK." ULP #1 said she was with another resident when she saw the AP walk outside (the facility) and "slam" a door. ULP #1 said she asked the AP what was wrong, and she told her the resident called her a name which made her upset. ULP #1 said she then went into the resident's room and saw his table tipped over, and things scattered around his room. ULP #1 said ULP #2 was in the room, talking to the nurse on the phone. ULP #1 said the resident's bedside table was on the ground. ULP #1 said the resident's cups and other personal items scattered around the floor. ULP #1 said the nurse told ULP #2, to send the AP home. ULP #1 said she went and told the AP to go home. ULP #1 said the resident was upset.

During an interview, ULP #2 said she was just down the hall from the resident's room and saw the AP leave his room then "slam" a door into the wall as she went outside. ULP #2 said the resident pushed his call pendant and she walked into his room. ULP #2 said the resident was screaming. ULP #2 said she saw cups all over the room, water on the floor. ULP #2 said the resident was sitting in his recliner chair, without pants on and his blanket on the floor. The resident told her he swore at the AP because she "yanked" and "yanked" the sling from under him which pinched his genitals. The resident said the AP pushed his table and everything "went flying." The resident said the AP threw his oxygen tubing and blanket to the ground, and walked out. ULP #2 said the resident was "panting" and told her he could not breath. The resident told ULP #2 he never wanted the AP in his room again. ULP #2 described the resident as being "very upset," trembling, and shaking. ULP #2 said she called the facility nurse, who told her to send the AP home. ULP #2 said ULP #1 helped her clean the resident's room. ULP #2 said she took photos of the resident's room and audio recordings.

During an interview, a facility nurse said she received a phone call from ULP #2 who told her what occurred. The nurse said while she spoke to ULP #2, the AP called. The nurse said the AP was defensive and told her the resident yelled at her and called her names. The nurse said the AP told her she pulled out the sling from under him "nicely" and did not cause the disarray in his room.

During an interview, a manager said she spoke to the resident the night of the incident and he was crying, distressed, and afraid. The manger said ULP #1 and ULP #2 helped calm the resident. The manager said she also tried to calm the resident and provide reassurance to him this would not happen again. The manager said she briefly spoke to the AP, but she was very vague about what occurred. The manager said the AP told her she did not come into work so the resident could "disrespect" her and she was not going to allow the resident to talk to her the way he did. The manger said the AP did not provide further details.

The AP's employee file indicated she started working for the facility less than one month before the incident. The AP received education on vulnerable adults, dementia, and resident mental illness. The facility provided the AP education on their standards of behavior including professional conduct.

Audio footage was unavailable.

The AP failed to respond to request for an interview, including subpoena.

The resident had some recall of the incident and stated there was a time someone hurt his scrotum because the straps were crossed. The resident said he told the AP to take them off, but the AP kept pulling and the facility told the AP to go home after. The resident said the AP was not a good person and did not want the AP to provide cares again.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and

(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

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

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

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

(2) The facility was in compliance with regulatory standards.

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

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

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

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

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: No. Attempted.

Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:

The facility provided re-education to staff regarding vulnerable adults.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Mower County Attorney

Adams City Attorney

Adams Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30231	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/13/2025
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NAME OF PROVIDER OR SUPPLIER CEDAR COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 810 WEST MAIN STREET ADAMS, MN 55909
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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
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL302314621C/HL302316163M</p> <p>On October 13, 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 21 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for HL302314621C/HL302316163M, tag identification 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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

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02360	<p>Continued From page 1</p> <p>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.</p> <p>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.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		