Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304385822M
Compliance #: HL304383741C

Date Concluded: October 31, 2025

Name, Address, and County of Licensee Investigated:
Cedars of Austin
700 1st Drive Northwest
Austin MN, 55912
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) neglected the resident when she silenced a door alarm without verifying the resident's whereabouts. As a result, the resident eloped from the facility and was later found outside, in the grass, on her knees.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP, an unlicensed caregiver (ULP), silenced the memory care door alarm without following the facility protocol to ensure a resident had not eloped from the unit. The resident left the facility and wandered around outside for approximately one hour until a community member saw the resident fall and called emergency services (911). The resident had pain in her neck at the time of the incident, then later discovered to have a broken bone of her neck.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed alarm systems, staff response to alarm systems, and the facility staffing structure.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer disease. The resident's service plan included assistance with medication administration, housekeeping, laundry, bathing, and toileting. The resident's nursing assessment indicated the resident had severe memory impairment and required staff to provide safety checks. The nursing assessment indicated the resident walked independently and wandered around the common areas. The assessment indicated the resident was a risk for elopement.

A facility incident report indicated the resound was found in the facility back parking lot around 7:00 p.m. The AP had last seen the resident in the memory care until wandering into another resident's room. The activity staff person report she came to the facility following a family picnic event and there were a lot of people present, coming and going from the building. The activity person reported a stranger had seen the resident fall and the resident was either hugging a tree to get up or holding on to prevent another fall. Emergency services was checking out the resident. The nurse assessed the resident. She had stable vitals and an abrasion to her nose. The facility verified the door alarms were working.

The medication administration records (MARs) indicated the resident did not receive Tylenol during the evening, but did receive it during the nighttime for neck pain after the incident. The MAR indicated the staff continued to give the resident Tylenol for neck pain.

Progress notes indicated four days after the incident staff observed the resident holding her neck and crying so they sent her into the emergency room.

Hospital records indicated the resident had a neck fracture. She required pain medication and a neck brace.

Medical records indicated the resident's health continued to decline and she passed away approximately one month later from complications of dementia. The medical examiner report indicated blunt force injuries of the head (from a fall) contributed to her death.

During an interview, an activities director said she left the facility for the evening and was driving her car out of the parking lot when she noticed the resident with people (community members) around her. The activities director said she parked her car and went to the resident. Local community members told her the resident fell, and they had called 911. The activities director said the resident had an injury above her eye, but she told emergency responders she

did not want to go to the hospital. The activities director said while she was outside with the resident, she called the nurse manager and told her what happened. The activities director said she stayed with the resident until other facility staff members arrived with a wheelchair and took her back into the facility.

During an interview, a nurse manager said she called the AP and informed her the resident was outside. The AP was not aware the resident eloped from the unit. The AP told the nurse manger the door alarm did not work, so the nurse manger asked another staff member (ULP #1) to check the door alarms, but they discovered the alarms were working properly. The nurse manager said she reviewed video footage the next morning and discovered the resident left the unit through the main entrance, but the AP responded almost immediately (within less than one minute) and shut off the alarm with her key. The nurse manager said video footage showed the resident just outside the door, in the facility entrance for “awhile” before she walked out of the front door and around the side of the building. The nurse manger said the video footage showed the resident “loose her footing,” hold onto a tree, swing around, fall to her knees, then to the ground. The nurse manger said the resident was outside of the building for one hour. The nurse manager said the security doors automatically unlock when someone applies pressure for fifteen seconds. (This is because of fire code regulations.) The nurse manger said the facility trained all their staff how to respond to an alarm. The nurse manager said their policy required staff to open the doors and look around for anyone, then count all the residents inside the unit to ensure no one eloped. The nurse manager said the AP did not follow this process.

During an interview, ULP #1 said she worked at a different unit during the time the resident eloped, however she brought the wheelchair outside to get her. ULP #1 said the resident complained of neck pain and rubbed the back of her neck, but 911 responders assessed her and thought the pain was from a pulled muscle. ULP #1 brought the resident back to the unit and checked the door alarm system. ULP #1 said the door alarms functioned properly and informed the AP. The AP told her she knew the door alarms were functioning, but she thought the alarm sounded because a visitor pushed the door. ULP #1 said she told the AP she should have followed the facility procedure and opened the doors to check if someone eloped, then counted all the residents. ULP #1 said she told the AP the resident had neck pain and to give her Tylenol (pain medication), then she left the unit.

During an interview, the AP said she was walking out of another resident’s room with soiled laundry in her hands, when she heard the door alarm. The AP said she silenced the alarm with her key, but it did not cross her mind someone went out the door. The AP said she thought it was a visitor who must have triggered the alarm. The AP said this was around suppertime in the evening, and she continued to tend to the suppertime duties. The AP said she received a phone call from the nurse manager who told her the resident was outside. The AP said the nurse manager asked her about the door alarm, however at this time she had been in the dining/lounge area and did not hear any alarm, so she told the nurse manager the alarm had not sounded. The AP said she forgot she silenced an alarm earlier in the evening. The AP said when the resident arrived back on the unit she complained her neck hurt. The AP could not

remember if she gave the resident Tylenol. The AP said staff members were supposed to check outside the door if the door alarm triggered. The AP said she wished she would have checked on everybody.

The AP's file indicated she participated in an elopement drill/test two months prior to this incident. The AP completed various dementia (memory loss) trainings throughout her employment including trainings on resident wandering and elopement.

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.

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 facility 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: No. Deceased.
Family/Responsible Party interviewed: No. Attempted.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided re-education to staff members. The AP no longer works for the facility.

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
Austin City Attorney
Austin Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30438	A. BUILDING: _____ B. WING _____	C 10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS OF AUSTIN	700 1ST DRIVE NW AUSTIN, MN 55912

(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: HL304383741C/HL304385822M On October 20, 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 112 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL304383741C/HL304385822M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 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 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.	02360		