Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304384322M
Compliance #: HL304388467C

Date Concluded: October 16, 2025

Name, Address, and County of Licensee Investigated:
Cedars of Austin
700 1st Drive NW
Austin, MN 55912
Mower County

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

Evaluator's Name: Erin Johnson-Crosby, 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 staff failed to administer the resident's medications according to physician orders and the resident required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to supervise administration of medications, and the resident missed 14 doses of an antiseizure medication. After the medication errors, the facility failed to complete and internal investigation and implement systemic changes to address medication administration procedures.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker. The investigation included review of the resident record, hospital records, facility incident

reports, staff schedules, related facility policy and procedures. Also, the investigator observed medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included dementia and seizure disorder. The resident's service plan included assistance with medication administration. The resident's assessment indicated severe cognitive impairment, and staff would administer all medications. The assessment indicated the resident did not have difficulties taking medications and was not able to self-administer medications. The assessment noted the resident received Keppra (antiseizure medication) for seizure disorder.

The resident medical record indicated the resident fell and sustained a finger fracture and laceration on the right cheek. The next day the resident was hospitalized for an increase in behaviors and non-compliance with medications.

Hospital records indicated the resident was admitted with confusion, inability to walk, right facial laceration, and deformity of the right hand following a fall. The resident's decline was suspected to be triggered by a seizure event and appeared the resident had not taken the ordered anti-seizure medication as ordered. The resident's Keppra level at the time of hospital admission was <1 (normal 10.0 to 40.0 mcg (microgram)/mL (milliliter)).

The discharge care plan indicated the family was cleaning out the resident's room and found 14 days of medications in the resident's room. The record did not include follow up regarding the medications that were found.

A picture taken by the resident's family member included 56 tablets for Keppra, 14 tablets of Lisinopril, and 27 tablets of melatonin. The picture showed the medication was intact.

Physician orders for the resident included Keppra 2,000 milligram (mg) daily for seizures, Sertraline 50 mg daily for depression, Lisinopril 20 mg daily for high blood pressure and melatonin for sleep. The resident's medication administration record (MAR) indicated staff should give medications and watch the resident take them and document any refusals.

A review of the resident's medication administration record for the last two months did not indicate the resident had refused medications. The resident's medical record did not indicate the resident's physician or family members were contacted regarding medications refusals.

During an interview, registered nurse (RN)#1 stated the resident would tell staff to leave the medications in his room, but staff were directed not to do that since he was not allowed to self-administer medication.

During an interview, RN #2 stated staff should not have left medications in the resident's room. The RN was informed of the medications the family members found, but did not complete an

internal investigation or follow up with the resident's family. RN#2 stated the resident may have been pocketing the medications.

During an interview, the resident's family members (FM) stated there were numerous occasions medications were found in the residents' room and were brought to staff. While the resident was in the hospital the family went to clean out the resident's room and found 14 days of Keppra including other medications. The family found the medications in medication cups, wrapped in tissues, or wrapped in foil. Some of the medications were found in a sock drawer and silverware drawer. The medications appeared intact as though they were never put in the resident's mouth. When the concern was reported to the facility no facility management provided follow up. The resident could have taken all 14 days of medications and overdosed. During hospitalization the doctor correlated the decline to the resident missing many doses of Keppra. A family member stated the doctors correlated the decline to missing many doses of Keppra.

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, due to cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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
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 07/29/2025

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: #HL304388467C/#HL304384322M On July 29, 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 120 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL304388467C/#HL304384322M, tag identification 1760.	0 000		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must	01760		

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01760	Continued From page 1 include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medication was administered as prescribed for one of one resident (R1) and failed to follow-up on medication administration practices when 14 doses of an anti-seizure medication were found in R1's room. R1 was hospitalized for a change in condition. 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include R1 was admitted to the facility on November 1, 2023, with diagnoses including seizures, dementia, depression, and hypertension,	01760	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.	

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01760	Continued From page 2 R1's 90-day assessment dated April 29, 2025, indicated unlicensed staff would administer all medications per the medication administration record. The assessment indicated R1 had no difficulties related to taking medications and was not a candidate to self-administer medications at that time. The assessment did not indicate R1 refused medications. The brief interview for mental status (BIMS) indicated R1 had severe cognitive impairment. The assessment also indicated R1 had a history of seizures and was taking Keppra. R1's service plan dated October 31, 2023, indicated R1 received medication administration twice daily. R1's physician's orders dated January 26, 2025, included orders for levetiracetam (Keppra) 500 milligrams (mg), take four tablets by mouth every night at bedtime for a total of 2,000 mg for seizure disorder. The orders also included Sertraline (antidepressant) 50 mg daily for depression, and Lisinopril 20 mg daily for hypertension (high blood pressure). R1's medication administration record (MAR) indicated directions for staff to follow when administering medications including wash hands, right resident, date, drug, dose, route, and frequency, give pills to R1 and watch them take them, document medications or refusals to take medications or why medications were not administered. Staff should notify the registered nurse (RN) of any concerns prior to administration of the medications. R1's April 2025, MAR indicated on April 7, April 10, April 27, and April 28, 2025, Keppra was not	01760	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.	

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01760	Continued From page 3 documented as administered. The notes did not indicate why the medication was not administered. On April 27, and April 28, 2025, Lisinopril, Melatonin and Sertraline were not documented as administered and the note section did not indicate why the medications were not administered. R1's May 2025, MAR indicated on May 25, 2025, medication administration was not documented, and the note section did not indicate a reason the medications were not administered. R1's June 2025, MAR indicated medications were administered from June 1, 2025, through June 5, 2025. The MAR indicated on June 6, 2025, medications were not administered because R1 did not answer the door. R1's medical record did not include notification to R1's physician or family indicating medication refusals. The licensee's medication error list did not include medication errors for R1. A picture sent by R1's family member (FM) included 56 tablets of Keppra, 14 tables of Sertraline, 12 tablets of Lisinopril, 27 tablets of Melatonin. The picture showed the medication was intact. R1's progress notes dated June 8, 2025, at 2:28 p.m., indicated R1 was brought back to the building by police at 1:00 a.m., since he had been out drinking. An incident report dated June 8, 2025, at 11:19 p.m., indicated R1 fell between the bed and the	01760		

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01760	Continued From page 4 wall sustained a fifth digit fracture and laceration on the right cheek. The root cause analysis indicated R1 had a urinary tract infection, had not taken medications for two to three days and had a history or alcohol use. R1's progress notes dated June 9, 2025, at 10:16, a.m., indicated R1 was transferred to another hospital and R1's family was notified. R1's discharge care plan completed on June 18, 2025, indicated R1 was hospitalized, and the family was seeking alternative placement for increased behaviors and noncompliance with medications. Family was cleaning out R1's room and found 14 days of medications in R1's room. R1's medical record did not include any other information regarding the medication. Hospital records dated from June 9, 2025, through June 25, 2025, indicated R1 was admitted with increased confusion, inability to walk, right facial laceration, and deformity of the right hand following a fall. R1's decline was suspected to be triggered by a seizure event and appeared R1 had not taken anti-seizure medication as ordered. The hospital record also noted at the time of admission R1's Keppra level was < 1 (normal range 10.0 to 40.0 mcg (microgram)/mL (milliliter)). On July 29, 2025, at 10:45 a.m., R2 stated some staff leave medications in her room and do not watch her take them since the staff was always in a hurry. On July 29, 2025, at 11:00 a.m., R3 stated some staff leave medications in her room for her to self-administer. R3 stated she always	01760		

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01760	Continued From page 5 remembered to take the medications if they were left in her room. On July 29, 2025, at 1:30 p.m., RN-A stated R1 was mostly independent but required medication management. R1 would tell staff to leave the medications in his room but staff were directed not to do that. R1 was not allowed to self-administer medications. R1 did refuse medications at times but that would be identified on the MAR by initialing the medication and circling it. RN-A was not aware the family found multiple medications in R1's room after discharge. On August 20, 2025, at 2:00 p.m., RN-C stated R1 received medication administration one time daily, and staff were supposed to administer and watch R1 take the medications. Staff should not have left medications in R1's room for R1 to self-administer. R1 did not have a history of refusing medications. RN-C was aware the family found multiple medications after discharge but did not know what medication was found or where the medication was found. RN-C did not contact the family to complete an internal investigation regarding the medications that were found. RN-C stated R1 may have been pocketing the medication. On August 28, 2025, at 9:00 a.m., R1's case manager (CM)-G stated nursing staff reported R1 would tell staff to let him take the medication to his room. CM-G stated on June 6, 2025, R1 told her he did not need him medications and the family informed him he did need to take his medications. On August 20, 2025, at 2:00 p.m., R1's family	01760		

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01760	Continued From page 6 member (FM)-E stated on numerous occasions medications were found in R1's room and were brought to staff and told staff to inform the director. FM-E stated on June 9, 2025, R1 was hospitalized after a fall with increased confusion, and a fractured finger. While R1 was in the hospital FM-E was cleaning R1's apartment and found 14 days of Keppra including other medications. The medications were found in medication cups, wrapped in tissues, or wrapped up in foil. Some of the medications were hidden in a sock drawer, and silverware drawer. FM-F stated the medications appeared intact and were never put in R1's mouth. FM-F stated R1 could have taken all 14 doses of that medication and overdosed. FM-E stated they no longer felt the facility was a safe place. FM-E and FM-F stated no one from the facility reached out regarding the medications that were found. FM-E and FM-F were not notified R1 had refused medications. FM-E stated the doctor correlated the decline to missing many doses of Keppra. The licensee's medication error policy dated, November 11, 2024, indicated when a medication error is discovered the RN or licensed practical nurse (LPN) will investigate to determine the cause, the person who made the error, and the potential harm to the client. The RN/LPN will contact the appropriate providers if determined necessary, which may include the client's family, physician, pharmacist and Minnesota Adult Abuse Reporting Center (MAARC). If the results of the investigation show that the error was a pattern of errors by a staff person, ensure appropriate follow up action is taken. If it is determined that changes are needed for systems, training, policies, procedures or if other action needs to be taken to prevent further	01760		

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01760	Continued From page 7 medications errors ensure that they are addressed and implemented. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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		