Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305192360M
Compliance #: HL305198540C

Date Concluded: July 23, 2026

Name, Address, and County of Licensee Investigated:
Cedar Lodge
195 24th Place Northwest
Owatonna, MN, 55060
Steele County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, facility and 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 facility neglected a resident when they failed to recognize the significance of her injuries after she fell and delayed obtaining advanced medical care. The resident required immediate medical attention including air lift transport to an alternate hospital location because she fractured her ankle and bone protruded her skin.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and alleged perpetrator (AP) were responsible for the maltreatment. The AP was a registered nurse, contracted to provide "after hours" (evening and night) nursing coverage. In this role, the AP was the facility's clinical decision maker. The AP did not perform duties consistent with nursing practice or facility policy when she failed to instruct unlicensed personnel (ULP) to obtain immediate medical care for the resident who fell and broke her ankle, so severe bone protrude through her skin and almost completed severed her foot from her body. The AP differed decision-making ability to a hospice agency which caused an additional delay in obtaining

medical care for the resident. In addition, ULP staff also failed to respond in a manner consistent with the facility's policy to call 911 immediately when serious injuries occur. ULP's were unaware they had the authority to act in such a manor because the facility instructed them to call the nurse before calling 911. Due to these failures, the resident remained on the ground, bleeding, in extreme pain without medication, with exposed bone for approximately one hour before emergency responders (911) arrived and took her to a local hospital. The resident required urgent "air lift" transportation to another (secondary) hospital for surgical repair.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, hospital records, hospice 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 staffing levels, documentation systems, and medication administration.

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD) and heart failure. The resident's service plan included assistance with bathing, and housekeeping. The resident's nursing assessment indicated she used an electric wheelchair, but was able to walk with staff assistance. She was able to communicate her needs and her memory was intact. The resident had a history of falling.

Resident records indicated she admitted into hospice care services following a recent hospitalization ten days before the injury occurred because of her COPD diagnosis. She received medication administration assistance from the facility.

An incident report indicated the resident fell at 8:30 p.m., sustained a compound fracture of her right ankle, and unlicensed personnel (ULP) #1 and ULP #2 witnessed the injury. The report indicated staff called 911. The report indicated staff also called the on-call nurse. The report lacked further information regarding the events of the fall, or further timing of the events.

Progress notes, written by the AP at 8:50 p.m., indicated the AP received a phone call from staff to inform her the resident's legs gave out while walking so staff assisted the resident to the floor. The resident said she had pain in her right extremity but was initially able to move. During attempts to lift her, staff observed the resident's ankle bone protruding through her skin. The AP documented the resident required emergent evaluation and a hospice nurse was enroute, approximately 30 minutes away. The AP documented the resident "insists" the situation cannot wait. The AP instructed staff to call 911 and at 9:40 p.m., the resident was enroute to the local hospital.

On-call nurse triage record call logs indicated ULP #1 called The AP at 8:48 p.m. to report the initial fall. ULP #1 called the AP again at 8:58 p.m. Audio recordings were not available, but artificial intelligence (AI) transcript indicated ULP #1 told the AP the resident had a compound

fracture in her ankle. At 9:21 p.m., the AI transcript indicated the AP told staff (name not identified) to contact 911.

The facility's medication administration records indicated the resident did not receive any pain medication after she sustained the injury, although she had oxycodone (narcotic pain medication) available to administer.

Hospital records from the initial hospital indicated the resident arrived at the hospital approximately an hour and 30 minutes after she sustained the injury. Due to the traumatic injury, 911 responders alerted "air personnel" (helicopter) so they could prepare to take the resident to a secondary hospital. Photo images showed the resident's right foot turned outward greater than ninety degrees and almost completely severed from her lower leg with the tibia (leg bone) protruding. The resident required intravenous (IV) pain medications. The physician immobilized the resident's leg and sent her to a secondary hospital by helicopter transport.

Secondary hospital records indicated the resident required surgery for her ankle fracture. The resident required multiple IV pain medications, and antibiotic medications (prevent infection). The resident also had a blood clot in her lungs which contributed to her stay in the intensive care unit (ICU).

During an interview, ULP #1 said the resident had repeated falls, so the facility required two staff members to walk with her. ULP #1 said ULP #2 was with her at the time of the incident. ULP #1 said they walked the resident from her bathroom, into her living room when the resident's ankle "snapped." ULP #1 said they lowered the resident to the floor and called the on-call nurse (AP). ULP #1 said the AP told them they could get the resident up off the floor. ULP #1 said when they assisted the resident up to her feet, the resident took one step, and the resident's bone "snapped" though her skin. ULP #1 said she saw blood and bone. ULP #1 said they lowered the resident back down to the floor. She called the AP and told her the resident's bone was "sticking out." ULP #1 said the resident was on hospice care, so they could not call 911. ULP #1 said the AP called hospice, but did not give her instructions how to manage the resident's injury or bleeding. ULP #1 said the AP called her and told her the hospice nurse was about 30 minutes to one hour away and they were supposed to wait for her arrival. ULP #1 said she felt it was unfair to make the resident wait for a hospice nurse to arrive. ULP #1 said the AP eventually gave her permission to call 911. ULP #1 said she followed the facility's "rule" to call the on-call nurse first.

During an interview, ULP #2 the resident was already on the floor when he arrived. ULP #2 said the resident had minimal pain in her ankle, but she did not think her ankle was broke, so the AP told them they could get her up off the floor. ULP #2 said the resident took one step and the injury occurred. ULP #2 said he saw bone protrude through the resident skin. ULP #2 said the resident's pain increased as time elapsed between the back and forth phone calls. ULP #2 said the resident was "insistent" to go to the hospital. ULP #2 said it took about 45 minutes to an hour before they called 911. ULP #2 said nobody should have had to wait for medical attention.

ULP #2 said the AP did not give instructions how to manage the wound. ULP #2 said it was the facility's policy to call the on-call nurse before calling 911.

During an interview, a hospice nurse said the AP called her and told her the ULPs "thought" the resident's bone was protruding through her skin. The hospice nurse said the ULPs were not licensed staff members, so she got ready to go to the facility to assess the resident's injury. The hospice nurse said she was about 25 minutes away, but the AP agreed with this course of action. The hospice nurse said the AP called her back and told her the resident was "screaming" she did not want to wait for her to arrive. The hospice nurse acknowledged she could not clinically manage bone protrusions.

During an interview, the AP said her role as the on-call nurse was to delegate to ULP's how to respond to emergent needs or situations. The AP said a ULP called her and told her the resident fell, but there was no injury, so she told them they could get the resident up off the floor. The AP said she received another call and a ULP told her the resident took a step forward and "rolled" her ankle. The ULP told her she could see the resident's bone protrude from the skin. The AP said she told the ULP the resident "probably" needed to go to the hospital, but due to protocol, she (herself) needed to contact the hospice nurse/agency. The AP said the hospice nurse told her she was about 30 minutes away and she would go to the facility to assess the resident. The AP said the hospice nurse told her to have the ULP's give the resident pain medication. The AP said she called the facility and gave them this information. The AP said the hospice nurse did not want them to send the resident to the hospital before she arrived. The AP said she made a series of phone calls (six to the facility and four to hospice) to coordinate the resident's medical care as required by the agency/facility policy. The AP said it was only 23 minutes between the initial call from the ULP who informed her the resident's bone protruded, to the time she told facility staff to call 911. The AP said the resident was probably only on the floor after the injury for about 30 minutes. The AP said this was actually, "not a bad time." The AP said she could not have called 911 before contacting the hospice agency because of the facility's policy. The AP said it was not only her responsibility to call 911, the resident or the facility staff (ULP's) could have also called 911 themselves. The AP said she felt she did everything within the facility policy and protocol and would act in the same manner if another situation like this occurred.

During an interview, a family member said he received a phone call late in the night from a staff member, but he was unsure if they were from hospice or the facility. The family member said the person told him the resident's bone protruded through her skin, but they were unsure if the resident should go to the hospital. The family member said this behavior was "inhumane." The family member said the facility did not call 911 until after they spoke to him which was about 30 minutes after the resident sustained the injury.

During an interview, the resident said she was on the ground for a "long time," was scared and in pain. The resident said ULP #1 and ULP #2 told her they could not call an ambulance until the

AP and hospice told them they could. The resident said she would never go back into hospice care because she had to wait to go to the hospital after having an injury like this.

During consultation with the resident's nurse practitioner, she expected staff to call 911 immediately if a resident sustained any injury with bone protrusion, even if the resident received hospice care.

During interview with multiple ULP during the onsite visit, ULP staff stated they did not have authority to contact 911 prior to calling a nurse first.

Facility policy regarding resident falls indicated staff were to "immediately" call 911 if a resident sustained a major injury and needed medical attention. Facility records also included a policy for how staff should respond to emergencies. The policy indicated staff should call 911 if they had any doubt about the seriousness of the resident's condition.

Facility records failed to indicate they completed retraining with verbal redirection to unlicensed staff to call 911 in major injury or serious condition situations nor took actions to prevent a similar occurrence.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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

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
Steel County Attorney
Owatonna City Attorney
Owatonna Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30519	A. BUILDING: _____ B. WING _____	C 06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

(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: HL305198540C/HL305192360M On June 25, 2026, 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 52 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for HL305198540C/HL305192360M, tag identification 2310, 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.	
02310 SS=L	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (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 standards. This MN Requirement is not met as evidenced by: Based on interview and record reviewed, the licensee failed to provide appropriate care and services in an emergency for one of one resident (R1) reviewed. R1 sustained a compound fracture (bone protrusion) of her ankle, and the licensee's staff allowed the resident to remain on the floor, bleeding, and in pain for approximately one hour before calling emergency services (911). This systemic failure had the potential to affect all residents. This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee for diagnoses including chronic obstructive pulmonary disease (COPD) and heart failure. R1's service plan dated December 19, 2024, indicated R1 required assistance with walking, bathing, housekeeping, and fall prevention. R1's nursing assessment dated February 20, 2026, indicated R1 re-entered the licensee after	02310		

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02310	Continued From page 2 hospitalization and admitted into hospice services (end of life). R1 had a history of falling, and multiple episodes of COPD exacerbations. R1 required medication management and assistance with dressing, toileting, and mobility. R1 walked, but required assistance of one staff member and a walker. R1 used an electric wheelchair for distance. R1 communicated her needs verbally and made herself understood. R1 scored 28/30 (memory intact/no significant impairment) on her mini mental exam. Incident report dated February 26, 2026, at 8:30 p.m., indicated R1 fell, sustained a compound fracture of her right ankle, and unlicensed personnel (ULP)-A and ULP-B witnessed the injury. The report indicated "staff" called 911. The report indicated "staff" also called the on-call nurse. The report lacked further information regarding the events of the fall, or further timing of the events. The report indicated the licensee took no action to prevent recurrence of injury or incident. Progress notes dated February 26, 2026, at 8:50 p.m. through 9:41 p.m., written by registered nurse (RN)-H, who worked for the licensee as the afterhours triage nurse. The notes indicated RN-H received a phone call from licensee staff (not identified), to inform her R1's legs gave out while walking so staff assisted R1 to the floor. R1 said she had pain in her right extremity, but was initially able to move. During attempts to lift her, staff observed R1's ankle bone protruding through her skin. RN-H indicated R1 required emergent evaluation and a hospice nurse was en-route approximately 30 minutes away. The note indicated R1 "insists" the situation cannot wait. The report indicated RN-H instructed staff to call 911 and at 9:40 p.m., the resident was	02310		

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02310	Continued From page 3 enroute to the local hospital. R1's medication administration record dated February 2026, indicated R1 had an order for oxycodone (narcotic pain medication) 2.5 milligrams every four hours as needed. R1's last dose received on February 26, 2026 was at 3:57 p.m. and did not receive any further doses after fracturing her ankle. Hospital records dated February 26, 2026, at 10:15 p.m., indicated R1 arrived at the emergency room and a physician evaluated her. R1 required intravenous (IV) pain medications, and antibiotics (to prevent infections). 911 responders recognized the severity of R1's wound and activated "air" (helicopter) transport. R1's diagnoses included distal fibular/lateral malleolus fracture with ankle disruption and dislocation (broken ankle bones). Hospital records indicated R1 had an open wound where her tibia went "completely through." Photo image from the hospital showed R1's right foot turned outward greater than ninety degrees, and almost completely severed from her lower leg with her tibia protruding through her skin. R1 required urgent air lift transportation to another hospital to salvage her severed limb. Hospital records (secondary hospital) dated February 27, 2026, at 12:34 a.m., indicated R1 also had a pulmonary (lung) embolism (blood clot) and required additional precautions for pain management because R1 also had COPD and a compromised respiratory system. R1 admitted into the intensive care unit (ICU). R1 required urgent orthopedic surgery. On-call nurse triage record call logs dated February 26, 2026, at 8:48 p.m. through 9:43	02310		

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02310	Continued From page 4 p.m., indicated ULP-A called RN-H at 8:48 p.m. to report the initial fall. ULP-A called RN-H again at 8:58 p.m. Audio recordings were not available, but artificial intelligence (AI) transcript indicated ULP-A told RN-H R1 had a compound fracture in her ankle. At 9:21 p.m., the AI transcript indicated RN-H told the licensee staff (name not identified) to contact 911. On June 25, 2026, at 8:27 a.m., the surveyor entered the licensee's building to conduct an on site investigation. The surveyor asked ULPs what action they would take if a resident fell and sustained significant injury. The following were the responses the surveyor received: -At 8:27 a.m., ULP-I said she would call on-call (agency nurse) prior to 911. ULP-I said she called 911 before calling the on-call nurse for a resident who had difficulty breathing and the licensee told her she had to call the on-call nurse first. -At 9:48 a.m., ULP-J said the licensee did not allow ULPs to call 911 before calling the on-call nurse. ULP-J was unsure if you could call 911 if something was serious, but if there was blood, or pain she would call the on-call nurse. ULP-J said even if a resident had a head strike, she would not call 911 before calling the on-call nurse. -At 10:11 a.m., ULP-K said the licensee required ULPs to call the on-call nurse before calling 911. ULP-K said she was "unsure" if she had the authority to call 911 before calling the on-call nurse. -At 11:36 a.m., ULP-L said the licensee required ULP's to call the on-call nurse first, not the ambulance (911), even if there was significant injury. On June 25, 2026, at 1:15 p.m., ULP-A said R1 pressed her pendant and wanted to go to the bathroom. ULP-A said ULP-B helped her walk R1	02310		

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02310	Continued From page 5 from the bathroom, back to her living room and R1's ankle "snapped," so they (both ULPs) lowered her to the floor. ULP-A said she called RN-H and followed her instructions. ULP-A said they got R1 up off the floor and when R1 took her first step her bone "snapped through." ULP-A said she saw blood and bone. ULP-A said there was a lot of blood. ULP-A said she called RN-H and told her what she saw. ULP-A said RN-H told her she had to wait for the hospice nurse to arrive in about thirty minutes to an hour. ULP-A said she told RN-H she was unsure if they should wait for that length of time. ULP-A said she spoke to RN-H multiple times and eventually RN-H told her to call 911. ULP-A said she thought it was unfair to have R1 wait that long. ULP-A said she was unsure if the licensee empowered her to call 911 before the on-call nurse. On June 29, 2026, at 1:42 p.m., ULP-B said the licensee's policy was to call the on-call nurse before calling 911. ULP-B said R1 was on hospice care, so they had to call the on-call nurse prior to calling 911. ULP-B said R1 remained on the floor for 45 minutes to an hour and said "no resident should be left like that, or anybody in general." ULP-B said R1 was insistent on going to the hospital, but the licensee's policy prevented him from calling 911. On June 30, 2026, at 4:32 p.m., family member (FM)-D said he received a phone call late in the night from a staff member (name unknown), who told him R1's bone protruded her skin, and they were unsure if they should send her to the hospital. FM-D said he became angry and told them to send her to the hospital. FM-D said this behavior was inhumane. FM-D said the licensee did not contact 911 until after they spoke with him, which was about 30 minutes after R1 sustained	02310		

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02310	Continued From page 6 her injury. On July 1, 2026, at 10:31 a.m., regional registered nurse (RN)-E said the licensee expected ULP's to contact on-call nurses before calling 911 unless the resident was unresponsive. On July 2, 2026, at 2:01 p.m., RN-H said she worked for a company contracted with the licensee as their after hours triage nurse. RN-H said in this role, her responsibility was to delegate to ULPs how to respond to emergent situations. RN-H said R1 was on hospice care, so the licensee's policy instructs staff to contact the hospice agency and follow their instructions. RN-H said she made six phone calls to the licensee and four phone calls to hospice to coordinate R1's care. RN-H said R1 was only on the floor for about 30 minutes after the injury occurred which was actually "not a bad time." RN-H said R1 could have called 911 herself or the ULPs could have called themselves, it wasn't only her who could have called. RN-H said she felt she did everything within the facility policy and protocol and would act in the same manor if another situation like this occurred. The licensee's policy titled, Falls, dated August 1, 2021, indicated staff would call 911 immediately if a resident sustained major injury and needed medical attention. Time period for correction: Seven (7) days	02310		
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	02360		

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CEDAR LODGE	195 24TH PLACE NW OWATONNA, MN 55060

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02360	Continued From page 7 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 and an individual person were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		