Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307304482M **Date Concluded:** September 22, 2025
Compliance #: HL307308949C

Name, Address, and County of Licensee Investigated:
Traditions of Montgomery
399 NW Lexington Ave
Montgomery, MN 56069
Le Sueur County

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

Evaluator's Name: Lena Gangestad, 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 by leaving the resident unattended on the toilet, later finding the resident lying on the bathroom floor.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility neglected the resident by not identifying nor delegating to the unlicensed caregivers the need for supervision during toileting. While multiple unlicensed caregivers were aware of the resident's need for supervision the facility had not included this on the resident's care plan.

While it was true an individual unlicensed caregiver left the resident unattended on the toilet, it was the facility's responsibility to identify the resident's needs and communicate interventions to the unlicensed caregivers. It was not within the scope of the unlicensed caregiver's authority to assess the resident's needs.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident's records, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia.

One evening, at approximately 7:00 p.m., unlicensed caregiver #1 assisted the resident to the bathroom. She left the resident sitting on the toilet and walked away to put clothes away. When she returned, the resident was found lying on the bathroom floor.

Unlicensed caregiver #1 immediately called the facility nurse, and both the hospice nurse and the resident's family were notified. As the resident was already on hospice services, the family decided not to send her to the hospital. Five days later the resident passed away.

An assessment dated two months prior to the fall indicated the resident required one to two caregiver(s) assistance with turning and repositioning in bed. The same document indicated the resident required a Hoyer lift and assist of two caregivers when getting out of bed. The same document indicated the resident required "full assist" with ambulation with a caregiver holding her hand and her gait belt. The same document did not include a description of what assistance the resident required with toileting.

A care plan dated soon after the resident's fall indicated the resident would utilize grab bars during toileting, she used pull-ups for incontinence and was to be checked every two hours by caregivers. The same document indicated the resident required "full toileting assistance" which included peri cares and a new brief. The document did not indicate specifically if a caregiver if a resident was required to stay physically present with the resident until she was off the toilet.

During an interview, the nurse stated the unlicensed caregiver #1 notified her and so she subsequently called the hospice nurse. Hospice staff checked on the resident the following day. The nurse said the care plan did not specify that staff were required to remain in the bathroom while the resident was toileting. She added the resident was generally stable on her feet and required one-person assistance with a walker.

During an interview, unlicensed caregiver #1 stated she had worked part-time at the facility for approximately six months at the time of the incident. She reported that she assisted the resident to the bathroom and then walked away briefly to put clothes away. She estimated the resident was out of sight for less than five minutes. Upon returning, she found the resident lying on the floor. She acknowledged that she should have remained with the resident but did not that evening. She stated she immediately called the nurse and requested assistance to move the resident to bed.

During an interview, unlicensed caregiver #2 stated the resident was often disoriented, with fluctuating good and bad days. She said that the resident ambulated well if staff walked alongside her. She further said that staff were expected to remain in the bathroom with the resident during toileting.

During an interview, unlicensed Caregiver #3 stated the resident sometimes required one-person assistance and at other times two-person assistance, depending on the day. She said when staff assisted the resident to the bathroom, they would remain present because the resident had a history of attempting to stand and walk independently. Even with staff present, the resident would sometimes still attempt to get up and move. She stated all staff were aware that the resident should not be left alone.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

“Not Substantiated” means: An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: No. The resident was deceased.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility reported the incident to the Minnesota’s Adult Protective Services. Family and hospice were notified.

Action taken by the Minnesota Department of Health: The investigation took place concurrently with a scheduled survey which issued correction orders on similar issues. See survey identified as SL30730016-0 citation number1640 and 2310.

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
Montgomery City Attorney
Montgomery Police Department
LeSuer County Sheriff's Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30730	A. BUILDING: _____ B. WING _____	C 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITIONS OF MONTGOMERY LLC	399 LEXINGTON AVENUE NW MONTGOMERY, MN 56069

(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: HL307304482M/HL307308949C. On July 25,2025, the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. The following correction order is issued/orders are issued for HL307304482M/HL307308949C: tag identification 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
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 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		