Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304385342M
Compliance #: HL304382462C

Date Concluded: November 5, 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: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

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 she fell down the steps in the entryway and hit the back of her head, causing a laceration.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident attempted to exit the secured memory care unit by pushing on a locked door that released after several seconds in compliance with fire safety regulations. The resident exited the door and fell down the stairwell, sustaining a head laceration. Staff members responded promptly, and the resident was transported to the hospital for evaluation and returned within 24 hours.

The investigator conducted interviews with facility staff members, including administrative staff, and family member. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include acute delirium. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The resident's assessment indicated she was using a walker with transfer and mobility.

The incident report indicated the resident was found lying on the floor at the bottom of the stairwell. The facility transported the resident to the hospital for evaluation and treatment. She returned to the facility within 24 hours with a laceration to her head.

During an interview, a manager stated the resident had moved into the facility approximately one month prior to the incident. The manager said the resident frequently wandered because she did not want to reside in the memory care unit and expressed a desire to return to her previous home. She stated the resident was generally steady and ambulated with a four-wheeled walker. The manager also said she reviewed the surveillance footage, which showed a double door leading to a stairway of approximately five steps down to the lobby. Although the door was locked and required a key fob to open, it would automatically release if held for several seconds, in accordance with fire code requirements. The resident approached the door, pushed it open, and fell down the stairs. Following the incident, the facility purchased two baby monitors to ensure staff could hear alarms even if one device were not functioning or had a depleted battery.

During an interview, the nurse stated all exit doors in the unit were equipped with alarms, locks, and keypads. Staff were required to enter a code to open the doors. She said the resident attempted to exit through one of the doors to reach the main entrance. Although the nurse was not present on the day of the incident, she was aware that the door alarm had been activated. She stated she was uncertain whether staff did not hear the alarm or did not respond in time. The nurse stated the resident opened the door, exited the unit with her walker, and fell down the stairs.

During an interview, a family member stated the exit door had a push-button release mechanism leading to the stairwell. The family member said the resident opened the door, fell down the stairs, and sustained injuries requiring transfer to the emergency room. She also said the facility placed a baby monitor near the door following the incident to ensure staff could hear the door alarm even when they were not in the immediate area.

In conclusion, the Minnesota Department of Health determined neglect was not 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, Unable to be interviewed due to dementia.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: Monitor in place at entrance to exit memory care unit and go to the main entrance. Staff have been educated to respond to alarms immediately. Resident has alarm in bed and in chair.
Reassurance checks increased.

Action taken by the Minnesota Department of Health: No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 09/10/2025

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 On September 10, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL304385342M/HL304382462C. No correction orders are issued.	0 000		