Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305192504M
Compliance #: HL305194411C

Date Concluded: June 16, 2025

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Inconclusive

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 report abnormal vital signs to the nurse practitioner (NP). As a result, there was a delay in the resident's medical care, and she became terminally ill (death imminent).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the staff failed to report abnormal vital signs to the nurse practitioner (NP) it could not be determined if this caused harm to the resident because her overall health was deteriorating. The resident went to the emergency room the day after staff recorded abnormal vital signs. The resident died from pneumonia and sepsis (life threatening infection).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's physician. The investigation included review of the resident record(s), death record, personnel files, staff

schedules, related facility policy and procedures. Also, the investigator toured the facility and observed documentation processes and staffing systems.

The resident resided in an assisted living facility. The resident's diagnoses included weakness, abnormal weight loss, high blood pressure, and kidney disease. The resident's service plan included assistance with dressing, grooming, bathing, meals, medications, and mobility. The resident's nursing assessment indicated she had a history of pneumonia (lung infection). The resident was alert, orientated and communicated her needs.

Two weeks prior to the resident's hospitalization nursing staff completed a nursing assessment of her health status. The assessment indicated the resident lost 27 pounds over three months. The resident told the nurse she had difficulty swallowing, and poor fitting dentures. The assessment indicated the resident did not like nutritional supplements and required hospitalization for electrolyte imbalances the month prior. The nursing assessment indicated physical and occupational therapist worked with the resident because of deconditioning (physical decline).

Approximately two weeks prior to the resident going to the hospital, the NP ordered the facility to check the resident's blood pressure weekly and tell her if the resident's systolic blood pressure (top number) was less than 90, or greater than 150. The following week, the NP ordered the facility to check the resident's pulse daily and tell her if the resident's pulse was greater than 90 beats per minute (bpm). The facility nurse included this information on the resident's plan of care which informed unlicensed personnel (ULP).

The resident's vital sign report indicated the resident's blood pressure one day prior to hospitalization was 83/60 and her pulse was 102 bpm. The record lacked indication the facility staff notified the NP the resident's pulse was greater than 90 bpm and blood pressure was less than 90.

Email communication from the resident's NP to the resident's family members and facility indicated the NP offered the resident's family the option to send her into the hospital due to her declining health status. The email indicated the resident's family chose not to send the resident to the hospital and they wanted to talk to the NP about hospice. The email communication occurred one day prior to the resident going into the hospital.

Progress notes indicated a nurse spoke to the resident's family about the resident's continued health deterioration and told them about hospice care (end-of-life). The family chose not to start hospice care. Progress notes indicated the next day, the resident's pulse was 111 (high), so the facility sent her into the hospital. Progress notes indicated the resident had pneumonia and sepsis.

The resident's death record indicated she died two days later from severe sepsis and pneumonia. The resident also had severe protein calorie malnutrition.

During an interview, a facility nurse said the resident's health deteriorated over the month prior to her death. The nurse said the resident would not eat. The resident's family even brought in food items for her, but she continued to eat poorly. The nurse said the resident's physical health continued to deteriorate and the week before her hospitalization, she was barley eating anything. The nurse said she saw the resident the day before the she went to the hospital and the resident seemed tired, but nothing seemed unusual. The nurse said the following day the resident was going to have a "tele-health" (video) visit with the NP. The nurse said during the tele-health visit, the NP reached out to the nursing staff and told them the resident's vital signs were abnormal and she needed to go to the hospital for possible sepsis. The nurse said she had no knowledge the resident's vital signs were out of range prior to the NP reaching out to her. The nurse said after the resident went to the hospital, she and another facility nurse looked at the vital sign report and discovered staff documented abnormal vital signs the previous day. The nurse stated the electronic health record system did not alert nursing of the abnormal vital signs, and the unlicensed personnel failed to verbally report it to a nurse.

During an interview, the NP said the family told her they were concerned about the resident's decline, weight loss and decreased appetite. The resident had specialty physicians evaluate her, and they tried other methods to increase her eating but were not successful. The NP said the resident's pulse was slightly higher, so she ordered an electrocardiogram (EKG). The NP said she told staff to check the resident's pulse daily and notify her if the resident's pulse was over 90 bpm. The resident's lungs were clear, and she had no complaints of shortness of breath. The NP said the resident's EKG indicated her heart rate was 102 bpm, slightly higher, but there were no other acute (immediate) concerns. The NP said six days later she received an email from the resident's family indicating the resident appeared weaker. The NP said the family member indicated they were concerned the resident was "slipping away." The NP said she told the family (though email) she was worried about the resident's decline and was concerned she had an infection, so she spoke to the family member directly. The NP said she told the family member the resident could go to the emergency room (ER) for lab work, however the family member declined and wanted to get lab work done at the facility. The NP said she scheduled a tele-health visit for the resident the next day, and told the facility to complete lab work later during the week. The NP said early the next morning she did a tele-health visit for the resident, with the resident's family member present. The NP said when she logged into the facilities computer system, she noticed the facility staff documented the resident's vital signs from the prior day. The documentation indicated the resident's blood pressure was low at 83/60, and her pulse was 102 bpm (high). The NP said the facility did not notify her of these results. The NP said she told staff to take the resident's vital signs again and the resident's blood pressure dropped to 53/35, and her pulse increased to 111. The NP said she told facility staff to immediately send the resident to the ER.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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. Deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided education to staff members on when to call the nurse.

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

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
	30519	A. BUILDING: _____ B. WING _____	C 05/27/2025

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: HL305194411C/HL305192504M On May 27, 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 40 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL305194411C/HL305192504M, tag identification 450 .	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.	
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to maintain a system for personnel to communicate changes in health care status for one of one resident (R1) reviewed. As a result of this systemic error, an unlicensed personnel (ULP) obtained R1's vital signs which were abnormal, but failed to notify licensed the a nurse. R1 required emergency medical care and died two days later. This practice resulted in a level three violation (a violation that harmed a client'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 a isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee for diagnoses including weakness, abnormal weight loss, high	0 450		

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0 450	Continued From page 2 blood pressure, and kidney disease. R1's service plan dated January 21, 2025, included assistance with her back brace, bathing, dressing, grooming, housekeeping, meals, and medications. The service plan indicated R1 required blood pressure and pulse checks monthly. R1's nursing assessment dated April 15, 2025, indicated R1 ate very little food and lost 22.4 pounds over three months. R1's current weight was 97 pounds. The assessment indicated R1 had aspiration pneumonia on January 12, 2025, along with a history of aspiration pneumonia. The assessment indicated R1's advanced directives included cardiopulmonary resuscitation. The assessment indicated R1 had low blood pressures, and a normal systolic range was 90-120, and the diastolic range was 60-80. The assessment indicated facility staff were to notify the nurse if R1's systolic blood pressure (top number) was below 90, or her diastolic blood pressure (bottom number) was below 60. The assessment indicated R1 required hospitalization from March 21, 2025, through Mary 23, 2025 for constipation and electrolyte imbalances. R1's care plan dated April 15, 2025, indicated she had low blood pressure and required staff to notify nursing if her systolic blood pressure was below 90, or her diastolic blood pressure was below 60. Physician order dated April 15, 2025, at 10:23 a.m., indicated the facility should check R1's weight weekly and report weight loss of one pound to the medical provider. The order indicated the facility should check R1's blood pressure weekly and report a systolic blood pressure less than 90, or greater than 150 to the medical provider.	0 450		

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0 450	Continued From page 3 Physician order dated April 22, 2025, at 11:49 a.m., indicated staff were to monitor R1's heart rate (pulse) daily and report if her heart rate as over 90 beats per minute (bpm). Physician order dated April 22, 2025, at 12:15 p.m. indicated R1 required an electrocardiogram as soon as possible. R1's vital sign report dated February 6, 2025, through May 6, 2025, indicated on April 28, 2025, no time, R1's systolic blood pressure was 83, and her diastolic blood pressure was 60. R1's pulse was 102 bpm. The report lacked indication what time of the day staff obtained the results. R1's service recap summary dated April 1, 2025, through April 30, 2025, indicated staff obtained R1's blood pressure and pulse on April 28, 2025, at 8:00 a.m. The service recap summary lacked indication what the results were. R1's nurse practitioner (NP)-D created an email chain with the facility nursing staff and R1's family members. On April 28, 2025, at 9:18 a.m., family member (FM)-E wrote a message on the email chain. The message indicated R1 was weaker, and very tired. R1 was unable to walk on her own. The email indicated NP-D was to evaluate her the following day. NP-D wrote in the email chain at 12:55 p.m. and asked if nursing and family thought R1 should go to the emergency room (ER). At 1:08 p.m., FM-E's response included, "I don't know". The email chain lacked indication the facility told NP-D, or FM-E R1's blood pressure was 83/60 and her pulse was 102 bpm which the ULP documented as completed at 8:00 a.m. Progress notes dated April 28, 2025, at 11:55	0 450		

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0 450	Continued From page 4 a.m., indicated FM-E spoke to the licensed practical nurse (LPN)-B who told her therapy (physical and occupational) discharged R1 due to lack of improvement. The progress notes indicated LPN-B spoke to FM-E about starting hospice care for R1, however FM-E wanted to talk with other family members before doing so. The progress notes lacked indication the licensee told NP-D, or FM-E R1's blood pressure was 83/60 and her pulse was 102 bpm obtained at 8:00 a.m. Progress notes dated April 29, 2025, at 9:08 a.m., indicated R1's pulse was at 111 bpm, and she went to the emergency room (ER) for possible sepsis. At 4:21 p.m., the notes indicated R1 admitted into the hospital with sepsis and pneumonia. Medical examiner death record indicated R1 died on May 1, 2025, from severe sepsis, and pneumonia. On May 27, 2025, at 2:18 p.m., LPN-B said the licensee's nursing staff included herself and one registered nurse (RN). LPN-B said she saw R1 on April 28, 2025, and told her therapy discontinued their services for her and also told her about her upcoming visit with NP-D on April 29, 2025. When she spoke to R1 on April 28, 2025, R1 appeared fatigued, but she did not notice anything outside of R1's baseline health status. LPN-B said NP-D reached out and told the nurses to send R1 into the hospital on April 29, 2025, for possible sepsis because R1's vital signs were out of range. LPN-B said she had no knowledge about R1's abnormal vital signs prior to NP-D telling her on April 29, 2025. LPN-B said after R1 went to the hospital, she reviewed R1's vital sign record with RN-C. LPN-B said the	0 450		

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0 450	Continued From page 5 computer system did not "flag" her with R1's had abnormal vital signs. The computer system only "flagged" RN-C. LPN-B said she put NP-D's orders for R1 into the licensee's computer system with parameters for when ULPs should notify the nurse and subsequently when the nurse needed to notify the physician/NP. LPN-B said the computer system "catches" when staff members enter vital signs which are out of range/parameters, then the system "flags" the nurse. LPN-B said they (LPN-B, RN-C) noticed the system only "flagged" the RN (not LPN-C or Administration) because their computer system listed the abnormal vital sign results as a "supervision" task. LPN-B said the licensee used the R-Task computer system. LPN-B said regarding abnormal vital signs, there would/should have been a blinking red area on the computer screen for the nurse indicating there was a new message, then the nurse would have had to click on it. The new message would have the resident's name, and she thought the message would say vitals were out of range, but LPN-B said she had never seen this before. LPN-B said she was unsure what would occur if the RN was not at the computer, or out of the building when the abnormal vital sign message was sent to her. LPN-B said when the ULP enters abnormal vital sign results into the computer system, they are supposed to notify a nurse by sending them a message thought R-Task, or verbally. LPN-B said the staff member would have to "click" a box for the "RN", "LPN", and "Administration", then the alert would have gone out to more staff members. LPN-B said the ULP did not send a message to the nurses through R-Task. LPN-B said she was at the facility the on April 28, 2025, when the ULP entered R1's abnormal vital signs into the system, but she was not notified through the system, or by the ULP	0 450		

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0 450	Continued From page 6 who took them. LPN-B said after the incident with R1's vital signs, she re-educated the ULPs about when to contact a nurse and the importance of telling nurses "face to face." LPN-B said her understanding about why the ULP did not report the abnormal vital signs was because she did not find it concerning. LPN-B said she has seen improvements with the ULPs notifying her and RN-C of things by sending them messages through R-Task. On May 27, 2025, at 3:21 p.m., RN-C said she was an agency nurse and started working at the licensee just prior to this incident occurring. RN-C said she was not aware R1 had abnormal vital signs on April 28, 2025, and if she had been aware, she would have investigated it further. RN-C said after the incident, she spoke to ULPs, and they told her the licensee's previous nurse told them they did not need to tell her (the previous nurse) about resident's abnormal vital signs because the previous nurse said they could see them on the computer. RN-C said sending a computer message does not indicate the nurse received the message, or received the message in "real time." RN-C said, even if ULPs "flag" her on a message, she would not get the message if she was not at her computer. RN-C said she spoke to the ULP who entered R1's abnormal vital signs into the computer system, and the ULP told her the reason she did not report the abnormal vital signs to nursing staff was because she (ULP) knew R1 was declining. The ULP told her R1's blood pressures were normally low, however RN-C said this was not substantiated by R1's clinical records. RN-C said the ULP assumed the low blood pressure was part of R1's decline. RN-C said R1 was not on hospice, and she did not have the opportunity to address the situation, because she was unaware of it. RN-C	0 450		

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0 450	Continued From page 7 said the computer system contained a dashboard report which gave a synopsis of the out or range vital signs. RN-C said she does not get messages, or "flags", but said she thought there was a way to "activate" that action though the R-Task system, but the licensee told her not to do it because the system would then send her message after message. RN-C said the licensee told her there was an area/box staff could "click" on that said something like "RN Notified", however the computer would not give her a message, this only indicated ULPs gave the RN a message. RN-C said there have been other times since this incident when she went into the "dashboard reports" and discovered other resident's out or range vital signs which ULPs should have reported to her. RN-C said she believed staff got mixed messages about what they needed to report, and she is trying to "deprogram" them. RN-C said she felt the ULP acted with more autonomy than they should have. On June 3, 2025, at 9:31 a.m., NP-D said on April 29, 2025, during her tele-health visit, she logged into the licensee's computer system and discovered the blood pressure and pulse results on April 28, 2025. NP-D told staff to check R1's vital signs and R1's blood pressure had dropped to 53/35, and her pulse increased to 111 bpm. NP-D told the licensee's staff to send her to immediately send R1 to the ER. NP-D said after this incident, she wanted to understand what the licensee's process was when they obtained abnormal vital signs. NP-D said licensee's staff told her the RN was automatically notified when the ULP enters an abnormal vital sign. NP-D said staff told her the RN is automatically notified through R-Task, however the RN was no longer employed at the licensee, and they had a temporary RN who did not get the information.	0 450		

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0 450	Continued From page 8 On June 4, 2025, at 1:16 p.m., the surveyor sent the licensee a request for policies including documentation, condition changes, provider (physician) communication. On June 5, 2025, at 11:26 a.m., the licensee sent the surveyor an email indicating communication is in the nursing assessment policy. The licensee's policy titled, Initial and On-going Nursing Assessment of Residents Under the Licensed Agency, dated June 6, 2023, indicated the licensee's nurses would communicate any new problems or concerns to the resident's physician or health care provider. Time period for correction: Seven (7) days	0 450		