Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL237481280M
Compliance #: HL237485520C

Date Concluded: May 5, 2026

Name, Address, and County of Licensee Investigated:
Bethany Assisted Living Facility
200 North Holcombe Avenue
Litchfield, MN 55355
Meeker County

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

Evaluator's Name:
Jana Wegener, 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 alleged perpetrators (AP1 and AP2) neglect the resident when they failed to provide necessary care and services to prevent falls. The resident fell and sustained a right humerus (arm) fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's record indicated the plan of care with interventions including scheduled toileting were provided. The resident attempted to self-transfer and fell with complaint of pain. Staff responded immediately when they heard the resident call for help and called 911. The resident transferred to the hospital for evaluation and treatment. When interviewed, staff and family stated the resident routinely transferred herself to the bathroom without assistance prior to the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed residents and staff at the facility.

The resident resided in an assisted living facility with diagnoses including muscle weakness (generalized), chronic kidney disease, and congestive heart failure. The resident's assessment and plan of care indicated the resident was able to make her needs known. She was at risk for falls due to poor endurance, muscle weakness, and memory impairment but had no falls in the last 90 days. The assessment and plan of care had fall interventions including stand by assistance with transfers, scheduled toileting, and adult day services.

The resident record indicated the resident had moved to a new room the day of the incident. The record indicated the resident's plan of care was followed with scheduled toileting and transfer assistance provided. The last documented time of completed service was approximately one hour prior to the incident. The record indicated the resident attended adult day services then returned to her room around 2:00 p.m.

An incident report indicated after the resident returned from adult day services, staff heard the resident say "ouch" and call out for help. The incident report indicated the resident had self-transferred in the bathroom. When staff responded the resident stated she tried to find toilet paper and fell. Staff called 911 and the resident was transferred to the hospital for evaluation. At the hospital, the resident admitted for a right humorous (arm) fracture. The incident report indicated the resident had a known history of unsafely self-transferring and falling.

A hospital after visit summary indicated the resident was seen in the emergency department after suffering a fall. The resident stated at that time to hospital staff she rose from the toilet to get a roll of toilet paper and fell with her arm outstretched. An X-ray indicated the resident sustained a mildly displaced right humorous fracture.

The facility investigation indicated adult day services staff brought the resident back to her room, assisted the resident to sit in her recliner, and turned on the television. The investigation indicated AP2 stopped in to see the resident then left. The investigation indicated a few minutes later AP1 heard the resident say "ouch" and called out for help.

When interviewed, AP2 stated she was on her way to change of shift report and stopped to see how the resident liked her new room. AP2 stated the resident asked where some of her things were and AP2 pointed them out for the resident, then left for report. AP2 denied the resident had rung for assistance or expressed needing anything before she left the room.

When interviewed, AP1 stated she was passing medications for another resident when AP2 stopped in to see how the resident liked her new room. AP1 stated less than 5 minutes later the resident called for help. AP1 responded immediately and called 911.

When interviewed, another staff stated the resident frequently toileted herself and needed reminders to use her call light for staff assistance.

When interviewed, the resident's family member stated the resident transferred herself to the toilet independently and would ring if she needed help. The family member stated the resident reported she had not called for staff assistance until after she fell. The family member denied concerns about care or services provided at the time of the incident.

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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP1 and AP2.

Action taken by facility:
Staff responded immediately, called 911, and the resident was transferred to the hospital for evaluation and treatment. Staff involved received re-education, and the incident was investigated.

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
	23748	A. BUILDING: _____ B. WING _____	C 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ASSISTED LIVING IN LIT	203 NORTH ARMSTRONG AVENUE LITCHFIELD, MN 55355

(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 March 4, 2026, the Minnesota Department of Health initiated an investigation of complaint HL237481280M/HL237485520C. No correction orders are issued.	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.	