Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL259042680M
Compliance #: HL259049722C

Date Concluded: June 10, 2026

Name, Address, and County of Licensee Investigated:
Bridgewell Assisted Living
410 West Main Street
Osakis, MN 56360
Douglas County

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

Evaluator's Name: Barbara Axness, 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 staff failed to notify the nurse of a change in condition. The nurse was not notified until two hours later and treatment was delayed for approximately five hours before the resident was finally sent to the emergency room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While there was a delay in care after a change in condition was observed, the resident still received timely care and was appropriately monitored at the facility. A few hours after the resident's inability to transfer was noted, he fell. Staff immediately notified the nurse who assessed the resident. The resident was sent to the emergency room and diagnosed with a subdural hematoma. The resident died a few days later.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed care and services at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and dementia. The resident's service plan included assistance with dressing, grooming, bathing, and comfort checks. The resident's assessment indicated the resident transferred independently and could walk with minimal assistance including reminders or encouragement. The resident had a four wheeled walker he used for mobility.

Approximately six months before the incident occurred, the resident was evaluated in the emergency room after falling and hitting his head. The resident fell again about three months prior to the incident and bumped his head but did not require medical attention. The resident's provider was updated on the fall. The resident was seen by his provider about a month before the incident with no significant changes noted.

Progress notes indicated at 5:00 a.m., staff noted the resident needed an assist of two to transfer and was dragging his right foot. The resident did not have any reported pain. At 6:45 a.m., staff found the resident on the floor next to his bed. The nurse assessed the resident who did not have any pain with movement or any visible injuries. The resident denied hitting his head. The resident was administered Tylenol at 7:15 a.m. as staff suspected he may have pain with the change to his gait. The resident didn't understand how to swallow the pills and chewed them instead. Two people tried to help the resident stand up and he had noted difficulty and needed extensive assist. The resident tried to walk but could only take "very short, shuffled steps, barely moving the right foot." The resident was noted to lean to the right side when sitting in his chair for a while. Staff did not notify the resident's family until two hours later. The resident's daughter was ok with sending the resident to the hopsital so he was taken to the emergency room.

Hospital records indicated the resident was diagnosed with a large acute-on-chronic left subdural hematoma (when new bleeding develops on top of an existing, older subdural hematoma. A hematoma is bleeding in the brain caused by trauma or an injury) Imaging completed six months prior did not show the hematoma. The resident transitioned to comfort cares and passed away two days later.

The resident's death record listed the cause of death as Alzheimer's disease. Other significant conditions contributing to death but not resulting in the underlying cause, included acute on chronic subdural hematoma.

During an interview, the unlicensed personnel (ULP) working the overnight shift the night of the incident stated the resident was normally independent and was often awake at night. The ULP

stated since the resident was independent, it was possible he could have had a fall that staff were not aware of. The ULP stated she checked on the resident every hour and the first few hours he was awake but sitting in his recliner and then when she checked on him again, he was asleep in his recliner. Since the resident didn't normally sleep well overnight, she let the resident sleep but continued to check on him. The ULP stated when she went to check on him at 5 a.m., he was still asleep which was unusual for him, so she woke him up and asked if he'd like to lie down in his bed. The ULP stated it was like the resident didn't know how to stand up so another person came to help, and they walked him to the bed but he was dragging his right leg a bit and had difficulty transferring. The ULP stated they got the resident in bed and he went to sleep and when she went back to check on him around 6 or 6:30 a.m. he was still asleep. When giving the day shift report, she brought the day shift staff into the room to show them how the resident was acting differently and that's when they found him on the floor. The ULP stated the nurse was immediately notified and they gave the resident Tylenol, which he didn't know how to swallow, and he tried chewing it. The ULP stated the nurse was already on the way to the facility when they called so she evaluated the resident in person.

During an interview, the facility nurse stated the resident was independent with walking and transfers. The nurse stated she was at the facility when the resident fell and assessed him. The nurse stated staff reported he was sleeping in a recliner when they transferred him to bed and he had difficulty with the transfer but they weren't sure if it was because he had been sleeping in the recliner so they continued to monitor him overnight. The nurse stated after the resident fell, they got him up and he was able to walk with standby assistance to the dining room but wasn't following cues like he normally did. The facility nurse stated she recalled the resident had walked into a wall instead of turning in the hallway and wasn't his normal self. The facility nurse stated the resident dragged his foot when walking with other staff but when she walked with him, he was able to lift his foot just not go past the other foot. The nurse stated the resident didn't have any facial drooping or changes to his strength and was still alert. The nurse stated it seemed like the resident was favoring one leg, so they gave Tylenol. The nurse stated they had conversations with the resident's family before about what they should do if something happened to the resident, so they had been trying to monitor at the facility before rushing to send him to the hospital. The facility nurse stated once it became clear the resident wasn't getting better, they called the family and made arrangements for him to be evaluated in the emergency room.

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, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility investigated the fall and reported the incident to MAARC.

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
	25904	A. BUILDING: _____ B. WING _____	C 05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWELL ASSISTED LIVING	410 WEST MAIN STREET OSAKIS, MN 56360

(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 May 1, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL259042680M/#HL259049722C. No correction orders are issued.	0 000		