Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL345682222M **Date Concluded:** August 4, 2025
Compliance #: HL345683847C

Name, Address, and County of Licensee Investigated:
Bridgewater at Mankato
630 Reed Street
Mankato, MN 56001
Blue Earth County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Michele Larson, 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):
An alleged perpetrator (AP), a facility licensed staff member, neglected a resident when the AP delayed the resident receiving medical treatment for her symptoms. The resident suffered for two days before being transported to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Documentation indicated the AP responded appropriately and sent the resident to the hospital in a timely manner. There was no documentation the resident requested staff to call 911 until the day the facility arranged for the resident to be evaluated at a hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member, and licensed health professional. The AP was interviewed. The investigation included review of

the resident record, hospital record, clinic record, facility incident reports, the AP's personnel file, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included chronic ureteral stents (tube inserted from the kidney to transport urine to the bladder), systemic lupus erythematosus (chronic autoimmune disease where the body's immune system mistakenly attacks its own healthy tissues and organs), chronic kidney disease, and diabetes. The resident's service plan indicated the resident required staff assistance of one with toileting and personal cares. The resident's history included frequent falls, dizziness, and lightheadedness. The resident was alert and oriented to person, place, time, and situation and made her needs known. The resident used a walker and manual wheelchair for mobility.

The resident's progress notes dated for a Wednesday, indicated the resident experienced a fainting spell while she sat on her commode. The facility immediately called 911. The resident told paramedics she got dizzy and lightheaded. The resident refused paramedics request to transfer the resident to the hospital, telling paramedics she felt better and wanted to stay at the facility.

That Friday morning, unlicensed personnel called the AP to the resident's room. The resident sat on her commode, slumped over with glazed eyes, droopy face, and was non-verbal. After a few seconds the resident responded and requested assistance back to her bed. Thirty minutes later while the resident stood during peri-cares the resident went limp and slumped over. The resident required a gait belt and three staff to assist her back to bed. The AP reported the episodes to the resident's provider and indicated staff were not able to safely transfer the resident to the commode. The resident's provider responded to the AP, "Does the resident need to go into the emergency department (ED) for eval?" The AP responded with "I spoke with her (resident) both times it happened and again after you sent the message, and she (resident) doesn't want to go."

The next day, unlicensed personnel sent a text to the AP stating the resident refused her medications twice because the resident was afraid she would throw up.

The following day, the AP documented the resident was "adamant" facility staff send her to the hospital. The AP indicated the resident did not take any medications Saturday or Sunday for fear she would vomit. Later that same morning, emergency medical services (EMS) transported the resident to the hospital.

The resident's hospital record indicated the resident presented at the hospital with nausea and vomiting for two days. The resident complained of lightheadedness, stomach and side (flank) pain. The resident was diagnosed with sepsis and acute kidney failure. The resident was discharged five days later to a short-term rehabilitation center with eventual transfer to a higher level of care.

During an interview, the AP stated she was the only licensed staff for the facility and was on-call for the facility 24 hours a day seven days a week. The AP stated unlicensed personnel contacted her Saturday morning stating the resident refused her medications afraid she would throw up but stated the resident never requested to go to the hospital until Sunday. The AP stated she checked in with staff later on Saturday stating staff told her the resident felt better, took her medications, and had no further complaints of feeling sick.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action was taken.

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
	34568	A. BUILDING: _____ B. WING _____	C 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT MANKATO	630 REED STREET MANKATO, MN 56001

(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 July 2, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL345683847C/#HL345682222M. No correction orders are issued.	0 000	Assisted Living Provider 144G. 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.	