Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349464946M
Compliance #: HL349461188C

Date Concluded: October 29, 2025

Name, Address, and County of Licensee Investigated:
Bridgewater at Owatonna
125 E Park St
Owatonna, MN 55060
Steele County

Facility Type: Assisted Living Facility (ALF)

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 alleged perpetrator (AP) sexually abused the resident by engaging in sexual intercourse with him during the night shift while on duty.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was not substantiated. The AP denied the event occurred and the resident refused to be interviewed.

The investigator conducted interviews with facility staff members, including administrative staff, mental health therapist, and unlicensed staff. The investigation included review of the resident's records, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses post-traumatic stress disorder. The resident's service plan included assist with medication administration.

According to the progress notes, one day the resident told an unlicensed caregiver that he and the AP had a sexual relationship while she was working at the facility.

During an interview, a professional who worked with the resident the resident told him he had oral sex with the AP during the night and afterwards did not respond to his text messages or phone calls. The professional stated he had no firsthand knowledge of this event but was sharing what the resident said to him.

During an interview, the manager stated he was not aware of the allegations until staff reported to him. At that time, the AP was no longer employed at the facility, so he did not interview her.

During an interview, the AP stated she had worked at the facility for nine months and had provided care to the resident in the past. She said that she mostly worked evening shifts and denied ever touching or having sex with the resident.

When approached for an interview, the resident declined.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, the resident refused.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility reported the incident to the Minnesota's Adult Protective Services and offered emotional support to the resident.

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
	34946	A. BUILDING: _____ B. WING _____	C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST 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 On September 9, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL349464946M/HL349461188C . No correction orders are issued.	0 000		