DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349467842M
Compliance #: HL349463540C

Date Concluded: February 18, 2025

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 the facility left him in his electric scooter for three days and did not reposition him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility did not coordinate a plan with hospice to put a plan in place to charge the resident's Hospice-provided battery-operated Hoyer lift. When a battery charger was not found in the resident's room, a caregiver took the Hoyer lift battery to another area for charging. The facility did not locate another battery for three days and the resident remained in his electric scooter during that time. While the resident did have a history of refusing to transfer off his electric scooter, the facility had not documented a transfer was offered to the resident nor that he refused during those three days.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident, a family member, and hospice staff. The investigation included review of the resident's assessment, service plan, progress notes, vulnerability assessment & individual abuse prevention plan, hospice notes, and home care agency notes. The investigation also included review of the resident's Bill of Rights. Also, the investigator observed resident's use of electric scooter for mobility along with staff and the resident interactions during a recent visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included type II diabetes, below the knee amputation, multiple mental health concerns, nicotine dependence, chronic pain and obesity.

The resident's service plan indicated the resident required transfer via a Hoyer lift. The same document directed caregivers to offer the resident a transfer out of his electric scooter and into bed every four hours for one hour to offload and provide pressure relief related to wounds. The resident's service plan included behavioral monitoring for refusals of care such as showering, dressing, and transfers. The resident was enrolled in hospice.

One weekend the resident reported spending three days in his electric scooter without being transferred out of the scooter into bed. The resident's battery used to operate the Hoyer lift used to transfer the resident was not located in the resident's room. No battery was located until hospice brought in an additional battery on Monday.

Review of email communication between several individuals of the resident's health care team indicated the resident had been in his electric scooter from Friday afternoon until an undetermined time on Monday. These documents indicated one of the facility caregivers removed the battery from the resident's room, which may have been because the resident may have lost or misplaced the battery charger and so the battery was taken to another location within the facility to charge. The email communication indicated over the 3-day period it was uncertain whether staff followed the resident's care plan and asked to lay down once over the weekend. It remained unclear if caregivers did not lie him down due to being unable to find the lift battery or the resident choosing to remain in his chair. The email discussion included steps to prevent confusion regarding battery charging in the future.

During an interview, unlicensed caregiver stated she removed the battery and brought it to an area on the second floor of the building to charge but was called to assist another resident and forgot about the battery. The caregiver stated she did not work the weekend and did not pass on to other staff where the battery was located. The caregiver stated she could not find a charger in the resident room and had never had to charge this resident's Hoyer battery previously. The resident did have a history of refusing to lay down and at times remained in his scooter for long periods of time

During an interview, a hospice employee stated the resident was unable to transfer himself safely. The hospice employee stated the resident reported to hospice staff he had been left in his electric scooter one weekend for a three-day period. When hospice staff arrived at the facility the following Monday for cares the battery for the Hoyer lift could not be found and there was no way for the resident to be transferred out of his scooter.

During an interview, a nurse stated the resident's care plan had been updated to indicate staff were to use the Hoyer lift to transfer the resident and to encourage the resident to lay down to relieve pressure due to wounds. The nurse stated there was no common area in the facility where resident batteries for their specific equipment are to be charged and charging of the batteries is completed in each resident room who has equipment. The nurse stated the facility is responsible for training staff on the Hoyer lifts, but that equipment is not owned by the facility. The nurse stated staff are trained on hire how to use a Hoyer lift but not on each specific Hoyer that is provided by hospice. The nurse stated no refusals were documented to indicate caregivers offered to transfer the resident out of his scooter and the resident would have been in his chair for the three-day period.

During an interview, a manager stated the resident directed his own care and has the right to decline services when offered. The manager stated staff at the facility attempted to reinforce hospice orders and the Hoyer lift is provided by hospice and was a battery-operated lift.

A review of the resident's medical record identified no instructions to caregivers to charge the Hoyer lift battery nor where to charge it as coordinated by hospice nor the facility.

A review of the resident's medical record did not identify action taken by the facility to address the missing battery until after the weekend had passed on Monday.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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.
(d) For purposes of this section, a vulnerable adult is not neglected for the sole reason that:

(1) the vulnerable adult or a person with authority to make health care decisions for the vulnerable adult under sections 144.651, 144A.44, chapter 145B, 145C, or 252A, or sections 253B.03 or 524.5-101 to 524.5-502, refuses consent or withdraws consent, consistent with that authority and within the boundary of reasonable medical practice, to any therapeutic conduct, including any care, service, or procedure to diagnose, maintain, or treat the physical or mental condition of the vulnerable adult, or, where permitted under law, to provide nutrition and hydration parenterally or through intubation; this paragraph does not enlarge or diminish rights otherwise held under law by:
(i) a vulnerable adult or a person acting on behalf of a vulnerable adult, including an involved family member, to consent to or refuse consent for therapeutic conduct; or
(ii) a caregiver to offer or provide or refuse to offer or provide therapeutic conduct; or
(2) the vulnerable adult, a person with authority to make health care decisions for the vulnerable adult, or a caregiver in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the vulnerable adult in lieu of medical care, provided that this is consistent with the prior practice or belief of the vulnerable adult or with the expressed intentions of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: The facility ordered a backup charger after this event had occurred.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Steele County Attorney
Owatonna City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34946	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 01/07/2025

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 ******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: HL349463480C/#HL349467802M, HL349469661C/HL349466406M, and HL349463540C/HL349467842M On January 7, 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 42 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL349463540C/HL349467842M, tag identification 0730, 2310, and 2360.	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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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(14) a discharge summary, including service termination notice and related documentation, when applicable; and
(15) other documentation required under this chapter and relevant to the resident's services or status.

This MN Requirement is not met as evidenced by:
Based on interview and record review the licensee failed to ensure documentation of incidents involving the resident and actions taken in response to the needs of the resident were completed for one of one resident (R1) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents 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 facility on January 20, 2023, with diagnoses of morbid obesity, below the knee amputation, depression, diabetes mellitus type 2, and congestive heart failure.

Review of R1's service plan dated, October 9, 2024, indicated effective February 1, 2024, the resident was transfers with assistance of two staff and a Hoyer lift. The assessment indicated if unable to safely transfer staff are then to use the EZ stand.

Review of R1's progress notes failed to show

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documentation of an incident that occurred where resident remained in his electric scooter over the weekend and facility staff were not able to locate the battery for the Hoyer lift in the resident's room. The progress notes also failed to indicate action taken to resolve the issue of the battery for the Hoyer.

During an interview on January 7, 2025, at 10:42 a.m., R1 stated he requires his electric scooter for mobility and a Hoyer lift for transfers.

During an interview on January 7, 2025, at 1:42 p.m., licensed practical nurse (LPN-E) stated R1 was on hospice and being treated for open wounds on back of his leg, below the knee amputee wound, and wounds to remaining lower extremity and foot. LPN- E stated the resident has a history of remaining in his chair for long periods of time, however, resident's care plan indicated caregivers are to encourage him to lay down and get out of his chair every four hours for a one-hour period. LPN-E stated a caregiver transferred the resident to his scooter on the afternoon of December 6th, 2024. LPN-E stated battery was removed from the resident room for charging. Over the weekend staff did not document services provided to the resident as care planned. LPN-E stated it was reported the resident had been in his electric scooter from an undetermined time on December 6, 2024, until December 9, 2024. LPN-E stated this was not abnormal behavior for R1 as he frequently refused cares.

During an interview on January 22, 2025, at 4:27 p.m., social worker (SW-H) stated prior to the order for the Hoyer lift the resident was being transferred with an EZ stand which was no longer safe. SW-H stated the Hoyer lift was provided by

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hospice. SW-H stated a member of the hospice team arrived at the facility on December 9, 2024, and was informed by R-1 he had been sitting in his electric scooter since December 6, 2024, as staff was unable to find charger for battery and battery was taken out of his room to an undetermined location to charge. When hospice arrived on December 9, 2024, hospice staff was unable to find the battery for the Hoyer lift. R-1 stated to hospice staff that he had requested one time over the weekend to be transferred, but the staff did not have a means to transfer him with the battery missing.

During an interview on January 23, 2025, at 9:30 a.m., management (Mgt-A) stated the resident directs his own care and can decline. Mgt-A stated he was aware of hospice having had conversations about the importance of being out of his chair due to his wounds. Mgt-A stated the facility staff would be the ones to reinforce hospice orders. Mgt-A stated he chose to be in his scooter the entire weekend and was able to use his call pendant to request assistance.
During an interview on February 11, 2025, at 8:41 a.m., Mgt-A stated the leadership team met regarding the report of R1 remaining in his scooter for a three-day period and determined a incident report was not needed as the facility was not negligent. Mgt-A stated the meeting was not documented.

Further review of R1's record did not identify an incident occurred December 6, 2024, through December 9, 2024, or documentation that services had been provided as identified in the service plan.

The licensee's Reporting, Documenting and Reviewing Incidents Involving Residents dated

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0 730	Continued From page 5 July 30, 2024, indicated incidents involving residents will have a corresponding incident report and follow-up will be completed as appropriate. The RN will document in the resident's chart the details of any incident involving the resident and their assessment including the follow-up actions that were taken. The RN will review the incident report with quality management team and document the review. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure facility services were provided using a service plan subject to accepted health care standards for one of one resident (R1). The facility was provided with an order to use a Hoyer lift (electrical device with a sling to transfer resident with limited mobility) for all transfers of R1 along with offering every four hours to lay down in bed. The facility failed to provide the service as listed on the care plan and failed to document the service as offered and document refusals. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310		

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safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents 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 facility on January 20, 2023, with diagnoses of morbid obesity, below the knee amputation, depression, diabetes mellitus type 2, and congestive heart failure.

R1's change of condition assessment dated October 9, 2024, indicated R1 required adaptive equipment for transfers and a wheelchair/electric scooter for mobility. This assessment indicated no devices were used for transfers and was independent with transfers.

Review of R1's service plan dated, October 9, 2024, indicated effective February 1, 2024, the resident was transfers with assistance of two staff and a Hoyer lift. The assessment indicated if unable to safely transfer staff are then to use the EZ stand.

Review of the resident's progress note dated November 20, 2024, indicated new orders from hospice to discontinue use of the EZ Stand (sit to stand lift with use of a machine) and to start using Hoyer lift for all transfers. This same note indicated this transition can only occur once the facility has the correct Hoyer sling to be provided by hospice.

Further review of the resident's progress notes did not indicate the actual date the new Hoyer

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sling was delivered to the facility and the date the Hoyer lift was initiated.

R1's hospice note dated, December 4, 2024, indicated the resident was to be Hoyer lifted into his bed every 4 hours for 1 hour to off load off his bottom.

R1's service agreement indicated effective December 5, 2024; staff were to encourage the resident to lay down in bed every 4 hours for one hour to off load. The equipment to be used for the transfer included the Hoyer Lift Sling and Hoyer lift.

Review of services received indicated no transfer with physical assist of two was offered or completed on December 6, 2024. On December 7th, the overnight staff signed off there was a transfer. The service received report was missing any type of documentation the resident was offered to lay down December 6th through December 9th. This same documented did not indicate refusals from the resident.

During an interview on January 7, 2025, at 10:42 a.m., R1 stated he requires his electric scooter for mobility and a Hoyer lift for transfers.

During an interview on January 7, 2025, at 1:42 p.m., licensed practical nurse (LPN-E) stated R1 was on hospice and being treated for open wounds on back of his leg, below the knee amputee wound, and wounds to remaining lower extremity and foot. LPN- E stated the resident has a history of remaining in his chair for long periods of time, however, resident's care plan indicated caregivers are to encourage him to lay down and get out of his chair every four hours for a one-hour period. LPN-E stated a caregiver

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02310	Continued From page 8 transferred the resident to his scooter on the afternoon of December 6th, 2024. LPN-E stated battery was removed from the resident room for charging. Over the weekend staff did not document services provided to the resident as care planned. LPN-E stated it was reported the resident had been in his electric scooter from an undetermined time on December 6, 2024, until December 9, 2024. LPN-E stated this was not abnormal behavior for R1 as he frequently refused cares. During an interview on January 22, 2025, at 4:27 p.m., social worker (SW-H) stated prior to the order for the Hoyer lift the resident was being transferred with an EZ stand which was no longer safe. SW-H stated the Hoyer lift was provided by hospice. SW-H stated a member of the hospice team arrived at the facility on December 9, 2024, and was informed by R-1 he had been sitting in his electric scooter since December 6, 2024, as staff was unable to find charger for battery and battery was taken out of his room to an undetermined location to charge. When hospice arrived on December 9, 2024, hospice staff was unable to find the battery for the Hoyer lift. R-1 stated to hospice staff that he had requested one time over the weekend to be transferred, but the staff did not have a means to transfer him with the battery missing. During an interview on January 23, 2025, at 9:30 a.m., management (Mgt-A) stated the resident directs his own care and can decline. Mgt-A stated he was aware of hospice having had conversations about the importance of being out of his chair due to his wounds. Mgt-A stated the facility staff would be the ones to reinforce hospice orders. Mgt-A stated he chose to be in his scooter the entire weekend and was able to	02310		

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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
02310	Continued From page 9 use his call pendant to request assistance. The licensee Contents of Service Plans, dated July 30, 2024, indicated the facility will have a contingency plan that includes action taken if the scheduled service cannot be provided. The facility will implement and provide all services required by the current service plan unless unable for reasons such as, but not including resident refusal. TIME PERIOD FOR CORRECTION: Seven (7) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		