Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350512461M
Compliance #: HL350518902C

Date Concluded: July 27, 2026

Name, Address, and County of Licensee Investigated:
The Lodge
107 Bridgewater Way
Stillwater, MN 55082
Washington County

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

Evaluator's Name: Brandon Martfeld, RN, BSN, 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 the resident had falls related to concerns of staffing.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident sustained two falls in a month; the first fall was witnessed and the second was unwitnessed. There was not a preponderance of evidence that the falls were a result of insufficient staffing. During the investigation, other concerns were investigated and found to be not substantiated.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a hospice nurse. The investigation included review of the resident records, death record, hospital records, facility incident reports, service invoices, incident and accident report, and staff schedules. Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included atrial fibrillation (erratic heart rhythm), repeated falls, heart failure, cognitive impairment, and osteoarthritis of hip. The resident's service plan included assistance with activities of daily living, applying a topical medication, weekly laundry and housekeeping. The resident's assessment indicated the resident was alert, oriented, and forgetful. The resident's assessment indicated the resident was independent with mobility, transfers and toileting in his apartment. The resident required assistance with applying skin medication, had hospice services and was resistive to cares.

The resident's medical record indicated the resident had two falls in one month. A staff member witnessed the resident's first fall. The staff member was assisting the resident with transferring from his wheelchair into his recliner. The resident was unable to bear weight when the resident stood and was lowered to the floor by the staff member. After being lowered to the floor, the staff member notified the on-call nurse, emergency medical services, and the hospice agency. The resident's medical record indicated the resident was transferred to the hospital for an evaluation. A second fall occurred approximately five hours after the resident arrived back at the facility following a three-day hospitalization. The resident's medical record indicated the resident required a mechanical lift for transfers when he returned however the resident attempted to transfer himself out of bed and fell onto the floor. The resident sustained injuries and was transferred back to the hospital for an evaluation.

Hospital records indicated after the resident's first fall; the resident had a left buttock bruise and no fractures. The resident had severe arthritic changes in his hips, with bone-on-bone degeneration. The resident was hospitalized and upon return transferred to the facility's memory care unit due to cognitive decline and impairment. After the second fall, hospital records indicated the resident suffered skin lacerations to the left little finger, left forearm, left bicep, right forearm, right elbow, left lower eyelid, and forehead. The resident's injuries were cleansed and dressed. While in the hospital, the resident stated, "everything is my fault." After the second fall, the resident was hospitalized for approximately 4.5 hours and returned to the facility.

The resident death record indicated the resident died seven days after the second fall. The cause of death was coronary artery disease, atrial fibrillation and hypertension (high blood pressure).

Review of facility documents indicated facility staffing was adequate to provide the scheduled services for the resident.

During an interview, a nurse stated there were no staffing concerns at the time the resident fell. During the first fall the nurse stated she was assisting the resident with a transfer. The resident's feet got tucked under the wheelchair, he did not have the strength in his legs to push

up to transfer. The nurse stated emergency services were notified, and the resident was sent to the hospital for an evaluation. The resident came back to the facility and transferred to the memory care unit and the staff were to assist with transfers, but the resident was impulsive and thought he could transfer himself. The resident's second fall was on the memory care unit because he transferred himself.

During an interview, an unlicensed staff member stated the resident had returned that day from the hospital and had a family member visiting. The resident was found around dinner time after the family member left. An unlicensed staff member stated the resident required two staff and a mechanical lift for transfers. There were two staff members on the floor to complete cares and neither staff attempted to transfer the resident by themselves. The unlicensed staff member stated when the resident was found on the floor, a nurse was notified, and the resident was sent to the hospital for an evaluation.

During an interview, a hospice nurse stated after the resident's first fall, he became more forgetful. The resident moved into the memory care unit, had hallucinations, had increased confusion and fell. The resident did not like to request assistance from the staff. The hospice nurse stated there were two staff members in the memory care unit assisting residents and they did a good job.

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, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

After each fall, staff notified a facility nurse, emergency medical services, and had the resident transferred to the hospital for an evaluation.

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
	35051	A. BUILDING: _____ B. WING _____	C 07/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE	107 BRIDGEWATER WAY STILLWATER, MN 55082

(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 14, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL350512461M / #HL350518902C. No correction orders are issued.	0 000		