Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286869922M
Compliance #: HL286869823C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee Investigated:
Covered Bridge LLC
231 Washington Street
Holdingford, MN 56340
Stearns County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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 staff failed to address a change in the resident's condition following a fall, resulting in a delay of care. The resident was diagnosed with radial (forearm) fracture eight days later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident fell and had increased pain and swelling in his arm. Eight days after the fall, the resident was seen in the clinic with significant swelling, inability to move his fingers, and was diagnosed with a mild to moderately displaced radial fracture.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The investigation included review of the resident record, hospital records, facility incident reports,

personnel files, staff schedules, law enforcement report, and related facility policies and procedures. The investigation included an onsite visit, observations, and interactions between current residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety disorder, major depressive disorder, and memory impairment. The resident's service plan included assistance with meals, laundry, medication administration, and safety checks three times daily to monitor for fall hazards. The resident's assessment indicated the resident was orientated but occasionally required re-direction. The resident had not fallen in six months but was at high risk for falls. The resident was independent with dressing and transfers.

The facility incident report indicated the resident's bed broke causing the resident to fall out of bed around midnight. The resident's right arm was bleeding, so the resident applied a bandage and did not notify staff. The registered nurse (RN) and the licensed assisted living director (LALD) were notified the next morning, and the box spring was replaced.

The next morning, the medical record indicated the RN applied a two-layer compression bandage with barrier cream the skin tear. Management staff notified the resident's primary care provider (PCP) the resident rolled out of bed and had a sheer skin tear and requested a Mepilex dressing.

Over the next six days, the medical record indicated the resident complained of right arm pain and received Tylenol. The medical record did not include a focused assessment, updated service plan, direction for staff to monitor the right arm, when to notify the RN with changes, or notification of the resident's PCP regarding increased pain.

Eight days after the fall, the RN assessed the wound and wrapped the wound with a two-layer compression wrap. The resident reported limited range of motion in his right fingers and the RN advised the resident to make an appointment that week. An appointment was scheduled the next day. The medical record did not include a focused assessment, updated service plan, or notification of the resident's PCP regarding increased pain or decreased range of motion.

Nine days following the fall, clinic records indicated the resident said he fell when his bed broke and he hit his right elbow and arm. The resident was receiving Tylenol for pain management and that the Tylenol was not quite cutting it. The resident reported reduced range of motion and significant swelling was noted. He reported electric shock like sensation, swelling, and bruising in his hands and wrists. The resident's right hand, wrist, forearm, and elbow was tender and swollen; right wrist and right hand had decreased range of motion, decreased strength and were swollen. Significant edema and bruising of the right upper extremity from the elbow to the hand was noted. Elbow range of motion was significantly decreased secondary to pain and tenderness. Two pictures of the resident's right arm showed abrasions, bruising, and swelling. The x-ray confirmed a mild to moderately displaced radial fracture. Orthopedics was consulted and recommended a posterior long-arm splint (cast shoulder to hand) that was placed at the

clinic and would follow up with orthopedics to discuss outpatient versus surgical repair. The notes indicated the resident did not require surgery but required a long arm cast. Following the removal of the long arm cast, the resident had to continue non-weight baring status.

A police report indicated the resident broke his arm after his bed broke. The resident sustained a significant injury from the incident and did not receive medical attention for almost a week. The resident had significant bruising, swelling, skin abrasions, and a broken arm. The police investigator interviewed the physician assistant (PA). The PA stated the resident came to the clinic because of the pain. The PA described the resident's injury as significant with bruising and swelling that extended from the elbow to hand. The PA stated the injury looked severe for being a week old, x-rays were ordered and confirmed the resident had a fractured radius that typically required surgery and required follow up with the orthopedic center. The resident was placed in a splint. The PA stated the resident's injury was apparent and appeared significant just by looking at it and was alarmed at the time it took for the resident to be taken to the clinic for evaluation.

During an interview, an unlicensed personnel (ULP) stated the resident notified her about his broken bed and fall the next morning. The ULP notified management via text message regarding the resident's broken bed and fall. ULP stated the resident's arm was initially swollen and became more swollen throughout the week. ULP stated after the incident the resident began complaining of pain and requesting Tylenol.

During an interview, Management staff stated she was not aware of the resident's broken bed prior to the fall. Management staff stated that the box spring was sagging in the middle and was replaced immediately. Management stated the resident's wound looked "gnarly," with skin tears, a was a little swollen and was "pretty" black and blue. Management stated the resident complained of pain and staff administered Tylenol. Management stated she and the registered nurse (RN) were the only ones changing the dressing to the resident's right arm. Management also confirmed there was no documentation that the PCP was updated regarding the resident's increased pain or swelling.

During an interview, the RN stated she typically worked two days a week and was always on-call. She was notified the next day about the fall and stated post fall vital signs and an assessment were not completed. The resident did not initially complain of pain when she first observed the arm. The RN was aware the resident began complaining of pain, but did not know if a physician was notified. Eight days later, when the RN assessed the arm, the resident told her he couldn't squeeze his hand or move or extend his arm and she advised the resident to make an appointment for that week. The RN stated there was no treatment order for the resident's wound, but it was being changed every two to three days. The RN confirmed there was not an updated service plan, treatment record regarding the resident's arm. The RN stated there were also no documented directions for ULP's to monitor the arm, or when ULP should notify the RN. The RN stated she was more focused on the wound rather than the resident's whole arm. The RN confirmed there was not an assessment or update made to the resident's service plan

following the diagnosis of radial fracture and inability to bare weight or move his right arm when the resident was in a long arm cast.

During an interview, the resident stated during the night he woke up and tried to get out of bed, and his bed broke causing him to hit his arm on the bed frame. There was a lot of blood, so he bandaged the wound. The resident did not want to bother staff and informed staff the next day. The resident stated after the fall staff had to help him get dressed because he could not move his arm because it, "hurt like a devil" and he was not able to move his fingers.

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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, Resident declined.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action was taken.

Action taken by the Minnesota Department of Health:
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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Stearns County Attorney
Holdingford City Attorney
Holdingford Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Support

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVERED BRIDGE LLC	231 WASHINGTON STREET HOLDINGFORD, MN 56340

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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: #HL286869823C/#HL286869922M On May 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 10 residents receiving services under the Assisted Living license. The following correction order is issued for #HL286869823C/#HL286869922M, tag identification 2310, 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02310 SS=G	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 assisted living services were provided based on resident needs according to an up-to-date service plan and accepted healthcare standards for one of one resident (R1) who had a change in condition after a fall. Nursing staff failed to assess, monitor, and implement interventions following a fall with increased pain and decreased functional ability. Nursing staff also failed to update R1's assessment or service plan following a right arm radial fracture. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	02310	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.	

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02310	Continued From page 2 R1's medical record indicated R1 admitted to the facility on August 9, 2021, with diagnoses of anxiety, depression, and memory impairment. R1's 90 day assessment dated February 10, 2025, indicated R1 was alert and oriented but occasionally required re-direction. The assessment indicated R1 had not fallen in six months, but was at high risk for falls and required fall risk safety checks to monitor for safety hazards. The assessment indicated R1 had occasional pain in the right and left shoulder due to past shoulder surgery. The assessment indicated the resident was independent with dressing, and transferring. R1's service plan dated January 29, 2025, indicated R1 required assistance with meals, laundry, medication administration, and fall hazard safety checks three times daily. R1's incident report dated February 24, 2025, indicated R1's bed broke causing R1 to fall out of bed around midnight last night. R1 did not want to bother staff so he bandaged the wound. The report noted a skin tear to R1's right forearm. ULP notified registered nurse (RN)-C. Licensed assisted living director (LALD)-B checked the bed and noted the box spring was cracked and dipping. LALD-B replaced the box spring. R1's progress notes dated February 24, 2025, at 11:27 a.m., included RN-C was notified R1 fell last night and injured his right arm. RN-C applied a two layer compression bandage with barrier cream to the skin tear. At 1:59 p.m., a fax was sent to R1's primary care physician (PCP) noting R1 rolled out of bed last night, and had a 2 centimeter (cm) x 1.5 cm sheer skin tear wound. A Mepilex dressing was requested and ordered.	02310	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.	

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02310	Continued From page 3 R1's medical record did not include a post fall assessment or a treatment and therapy plan. There was also no treatment order for R1's skin tear. R1's February 2025, medication administration record (MAR) , indicated an as needed (PRN) order for acetaminophen (Tylenol) 500 mg take 2 tablets (1,000 mg) by mouth every 6 hours PRN for pain. R1 had not received Tylenol from February 1, 2025 through February 24, 2025. R1 requested Tylenol on February 25, February 26, and February 27, 2025, twice for arm pain. Despite R1's increase in pain and request for PRN pain medication, no pain assessment was completed. R1's medical record dated February 25, February 26, and February 27, 2025, lacked an assessment of R1's arm, direction for unlicensed personnel (ULP) to monitor R1's arm, or notification to R1's PCP regarding increased pain. R1's progress notes dated February 28, 2025, indicated LALD-B removed R1's current wound dressing and applied a Mepilex bandage. The note indicated RN-C was unable to view the wound and would assess on March 3, 2025. The note also indicated Tylenol would continue twice daily for five days for pain. R1's MAR dated February 28, 2025, included for acetaminophen 500 mg to be given twice daily for 5 days for arm pain. The order did not direct staff to give two tablets. R1's medical record did not include documentation staff assessed or monitored R1's right arm on March 1, and March 2, 2025. R1's medical record did not include a physician order for Tylenol or notification of R1's PCP regarding	02310		

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02310	Continued From page 4 increased pain. R1's progress note dated March 3, 2025, at 12:17 p.m., RN-C assessed the wound on R1's right forearm. RN-C lightly wrapped the wound with a two layers of compression wrap. R1 noted he had limited range of motion (ROM) in his right fingers and RN-C advised he schedule an appointment with a medical doctor (MD) this week. An appointment was scheduled for March 4, 2025. R1's progress notes dated March 4, 2025, at 10:39 a.m., indicated RN-C wrote, please evaluate R1's right forearm, and the limited ROM in his right hand, R1 was complaining of tendonitis. At 1:50 p.m., the MD evaluation report indicated a right arm radial fracture. A splint and sling were placed until orthopedic follow up. Orders for tramadol as needed (PRN) every 6 hours and continue Tylenol 1,000 milligrams (mg) every 6 hours for pain. The orders also included to elevate and ice R1's arm as needed. R1's clinic records dated March 4, 2025, indicated R1 reported an injury to his arm due to a bed collapse. R1 reported he told staff his box spring was broken multiple times and it was never fixed. R1 said he hit his right elbow and arm during the fall. R1 was receiving Tylenol for pain management and it was not cutting it. R1 reported reduced range of motion and significant swelling. He reports electric-shock like sensation, swelling, and bruising in his hands and wrists. R1 did feel the pain was slightly improving but continued to have significant edema. The note indicated R1's right elbow was swollen with decreased range of motion. R1's right forearm was tender and edematous (swollen), right wrist was swollen and tender, with decreased range of motion. R1's right hand was swollen with	02310		

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02310	Continued From page 5 decreased range of motion and decreased strength. Significant edema and bruising of the right upper extremity from the elbow to the hand was noted. Elbow movement was significantly decreased secondary to pain, tenderness to palpation along the proximal radial aspect of the right forearm. The clinic notes included two pictures of R1's right arm which showed the abrasion, bruising, and swelling. Orthopedics was consulted and recommended a posterior long-arm splint (cast shoulder to hand) that was placed at the clinic today and would follow up with orthopedics to discuss outpatient versus surgical repair. Imaging reports dated March 4, 2025, indicated a mild to moderately displaced fracture of the proximal radius involving the distal aspect of the radial tuberosity. A police report indicated R1 had a broken arm when his bed broke from underneath him while he was sleeping. R1 reported he asked supervisors at the facility to fix his bed on multiple occasions but nothing was done. R1 sustained a significant injury from the incident and had not received medical attention for almost a week. R1 had significant bruising, swelling, skin abrasions and a broken arm. The police investigator interviewed the physician assistant (PA). The PA stated R1 told her his injury was caused by his broken bed. R1 came to the clinic because of pain. R1 reported he had been taking Tylenol for pain but that was no longer helpful. The PA described R1's injury as significant with bruising and swelling that extended into his hand. The PA stated the injury looked severe for being a week old, x-rays were ordered and confirmed R1 had a fractured radius and typically required surgery and would follow up with the orthopedic center. R1 was placed in a splint. The PA stated R1's injury was apparent and appeared significant just	02310		

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02310	Continued From page 6 by looking at it and was alarmed by the time it took R1 to be seen by medical staff. R1's medical record did not include an updated assessment or service plan following the diagnoses of a right radial fracture and the inability to use R1's right arm and did not indicate the swelling and edema noted in to R1's arm injury. No monitoring or assessment of edema was included in R1's medical record. R1's March 2025 MAR indicated R1 received Tylenol 500 mg two tablets PRN 12 times throughout March 2025 and Tramadol 50 mg 16 times for pain. R1's clinic records dated April 8, 2025, indicated R1's cast was removed yesterday and was directed to continue with non-weight bearing for an additional 4 to 6 weeks until completely healed. On May 7, 2025, at 10:24 a.m., unlicensed personnel (ULP)-A stated the RN was usually onsite Monday and Tuesday. ULP-A stated she brought R1 to the clinic for a colonoscopy the day after he fell. R1 told her he fell out of bed around midnight but did not tell staff. ULP-A notified LALD of the fall via text messages and took pictures of R1's arm and sent it to LALD. R1 started to complainan of pain the next day and requested Tylenol. ULP-A stated a week later, R1's pain was worse so R1 agreed to go in to the clinic. ULP-A stated R1's arm was initially swollen and became more swollen throughout the week. On May 22, 2025, at 10:00 a.m., LALD-B stated her last day working at the facility was February 28, 2025, LALD-B stated she found out about R1's fall the morning after there fall. The box	02310		

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02310	Continued From page 7 spring was sagging in the middle and was replaced that day. LALD-B stated R1's wound looked "gnarly," with skin tears, a was a little swollen and "pretty" black and blue. LALD-B stated R1 complained of pain and staff were giving him Tylenol. LALD-B stated she and the RN were the only ones changing the dressing to R1's right arm. LALD-B also confirmed there was no documentation the primary care provider was updated regarding R1's increased pain or swelling. On May 22, 2025, 11:00 a.m., RN-C stated she typically worked two days a week and was on-call at all times. RN-C came to the conclusion R1 needed to use the bathroom during the night and fell. RN-C stated at the time she was notified of the fall but vital signs or a post fall assessment was not completed. RN-C stated R1 did not initially complain of pain when she observed a sheer wound. RN-C stated she added the Tylenol order the evening of February 28, 2025, but could not find the physician order and did not know what physician ordered the Tylenol. RN-C stated LALD-B probably took a verbal order for the Tylenol. RN-C stated a ULP could take a verbal physician order since she was not in the facility all of the time. RN-C did not know if a physician was notified of R1's increased pain and verified it should be documented but was not in R1's medical record. RN-C assessed R1's wound on February 24, 20-25, and March 3, 2025. On March 3, 2025, R1 told her he wasn't about to squeeze his hand or able to move or extend his arm. RN-C informed R1 to make an appointment with a physician this week. RN-C confirmed there was no treatment order for R1's wound, and she and LALD-D were changing it every two to three days. RN-C stated R1's service plan was not updated to include a treatment for R1's arm,	02310		

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02310	Continued From page 8 directions for ULP's to check R1's arm, and no monitoring of R1's arm pain, swelling, or condition and/or when they should notify the RN. RN-C stated she was more focused on the wound rather than R1's whole arm. RN-C also verified there was not an assessment or updated service plan following R1's radial fracture and inability to bare weight or move his right arm. On May 7, 2025, at 3:15 p.m., R1 stated prior to the incident, R1 had asked staff multiple times to fix his bed because it was broken. R1 stated during the night he woke up and tried to get out of bed, his bed broke and his arm hit the bed frame. There was a a lot of of blood so he bandaged it and did not want to bother staff and told staff the next day about the incident. After that, the staff had to help him get dressed because he could not move his arm. R1 stated his arm, "hurt like a devil" and he was not able to move his fingers. R1 stated he did not refuse to see a doctor. On May 30, 2025, at 9:00 a.m., case manager (CM)-D stated she was not notified of R1's fall or fracture and was not notified until R1 notified her on March 5, 2025. CM-D stated R1 would notify staff of his concerns. A change in condition policy was requested. The licensee provided a document titled, The Essential Guide Assisted Living in Minnesota. A policy was not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28686	A. BUILDING: _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02360	Continued From page 9	02360		
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 facilitywas responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	