Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303856384M
Compliance #: HL303852055C

Date Concluded: September 20, 2023

Name, Address, and County of Licensee Investigated:
Bridgeway Estates
103 12th Street NE
Little Falls, MN, 56345
Morrison County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 unknown facility staff member abused the resident when the staff member threatened the resident by shaking her first in the resident's face. The unknown facility staff member told residents she purchased a gun and said, "you bitches' better watch out." The staff member also called the resident a "lazy ass."

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. During the investigation a facility staff member was identified as an alleged perpetrator (AP.) There was not a preponderance of evidence to support the AP shook her fist in the resident's face or made the alleged comments. There were grievances the facility investigated and monitored involving the resident and the AP. The resident did not report she felt threatened, fearful, or unsafe with the AP. The resident said she felt safe living at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and the resident. The investigation included review of the resident's record,

assessments, personnel records, facility grievances and investigations, and policies and procedures. Also, the investigator observed the facility, the resident, and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included high blood pressure, anxiety, and disruptive behaviors. The resident's service plan included assistance with medication administration and bathing. The resident's assessment indicated the resident was alert, oriented, and vulnerable in giving accurate information consistently.

Review of a facility investigation indicated the resident reported to leadership, the AP was "very blunt and loud." The resident also reported during a conversation she had with another resident weeks prior, the AP threw her hands up in the air and said, "it's fine" "I'm over it." The resident denied being fearful of the AP. When interviewed the AP said the two residents were having a disagreement and the AP put her hands up and said, "it's fine you guys let's all get along" and they went their separate ways.

During the facility investigation, leadership observed the AP assisting with supper. The resident was present and there were no changes with the resident's and AP's behavior. When interviewed by leadership, the resident had no concerns, said she had a good evening and visited with the AP.

Five days after that, the resident reported she heard the AP loudly say "uh huh" after the resident made a comment to another resident during supper. The resident said no other comments were made and the resident said she had no concerns. The resident was content and agreed to have leadership continue to monitor how the resident was doing.

During an interview, leadership stated they investigated the resident's grievances, complaints, and monitored outcomes. Leadership stated they interviewed the resident and AP. During monitoring, the resident did not report she felt threatened, fearful, or unsafe with the AP. The resident said she felt comfortable and safe living at the facility. Leadership stated during observations of the AP there were no concerns with how the AP interacted with the resident, interacted with other residents, or the AP's job performance. The resident, other residents, and the AP all visited together frequently in the dining room. Leadership stated there were no concerns identified.

During an interview, the AP stated she did not say or do anything that could be perceived by the resident as intimidating or threatening. The AP stated she did not say anything or act in a way where the resident could have felt scared or fearful. The AP denied shaking her fist in the resident's face, telling the residents she had a gun and saying, "you bitches' better watch out," or calling the resident a "lazy ass."

During an interview, the resident stated the AP put her fist up to the resident's face but did not report the AP calling the resident names or threatening residents with a gun.

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;

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Responsible for self.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted investigations and monitored 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
	30385	A. BUILDING: _____ B. WING _____	C 08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWAY ESTATES	103 12TH STREET NE LITTLE FALLS, MN 56345

(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 August 30, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL303852055C/#HL303856384M. No correction orders are issued.	0 000		