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 #: HL345686746M
Compliance #: HL345682711C

Date Concluded: October 9, 2023

Name, Address, and County of Licensee Investigated:
Bridgewater at Mankato
630 Reed St
Mankato, MN 56001
Blue Earth

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Inconclusive**

Nature of the 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) abused a resident by clenching her fists and addressing her in an intimidating manner. The AP screamed at her, sent her to her room, and said she would not be allowed to leave until granted permission. Additionally, she was told to eat meals in her room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The investigator did not identify witnesses to the interaction between the AP and the resident. Additionally, evidence was not identified indicating the facility made the resident take her meals in her room.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted the resident. The investigation included review of resident's records and the AP's personnel record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses include bipolar and personality disorder. The resident's service plan included redirection regarding medication times and administration. The resident's assessment indicated she was independent with transfer and mobility.

One day the resident reported she asked the AP to intervene in an interaction between the resident and another resident. The resident said the AP became upset, became reddened in the face, clenched her fists, spoke to the resident in an intimidating manner, and told the resident to go her room.

A review of the resident's medical record did not identify documentation of the interaction between the resident and the AP. During the course of the investigation, no other people were identified as witnesses to this interaction.

During an interview, the resident stated she could not recall how the incident began, but she stated the AP confronted her by getting in her face and screaming at her. This experience scared her, as it was the first time. She went on to describe an incident where another resident did not eat their food, so the resident decided to take the uneaten food and place it on her own plate. In response, the nurse reprimanded her and told she was not supposed to do that. Subsequently, she retreated to her room, and later when she went to the kitchen, she saw a sign posted that read, "Room [the resident's room number] will be eating in her room until further notice." As a result, she had to eat her meals in her room for a period of 3-4 days before being allowed to dine in the communal dining room once again.

During an interview, the resident's case manager stated she was aware of the resident's concerns, but she did not personally observe a posted sign stating the resident will be eating in her room when she visited the facility. The case manager stated the resident's preferences was to have her own space for meals and at times found it challenging to have in meals in group settings. The resident no longer lived at the facility but had moved elsewhere.

During an interview, the AP stated she had a loud voice but denied screaming or yelling at the resident. She said the resident typically ate in the dining area, but sometimes ate in her room, especially when she was not feeling well. The AP did not recall the specific incident when the resident took food from others but noted that, generally, the resident was the one who often shared her food. The AP explained it was not recommended for residents to share food because they could not ensure its proper storage or whether it was expired. She denied ordering the resident to eat in her room.

During an interview, an unlicensed caregiver stated he worked full time at the facility on the day shift. He stated he never witnessed someone tell the resident to go to her room or take meals there. He explained it was the resident's personal choice to eat in her room and she often did so as it seemed to be her preference. The unlicensed caregiver denied seeing a posted sign

indicating the resident would be eating in her room. He stated he worked with the AP and had never witnessed the AP yell at the resident.

The Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, the resident is her own person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34568	A. BUILDING: ______ B. WING ______	C 09/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT MANKATO	**630 REED STREET MANKATO, MN 56001**

(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 14, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL345686746M/HL345682711C. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE