Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307236424M
Compliance #: HL307235165C

Date Concluded: April 8, 2026

Name, Address, and County of Licensee Investigated:
Mankato Lodge Senior Living
1360 Adams Street
Mankato, MN 56001
Blue Earth County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Inconclusive

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: The facility neglected the resident when a nurse was not notified about a fall. The resident suffered a fall with hip fracture and because of a lack of onsite nursing, did not receive facility nursing follow-up. Also, pain medications were not followed up on and given as ordered.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was inconclusive. While it was true the resident fell and the nurse was not notified, an unlicensed caregiver contacted the resident's family, and the resident went to the hospital for evaluation. Later the resident developed bruising, the family contacted, and the resident was sent to the hospital again. Regarding pain, it was possible administration of pain medication was delayed however it is not clear whether this was due to an error on the part of the facility or an issue with insurance coverage for the medication.

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

incident reports, and related facility policies. Also, the investigator observed residents and staff supervision of care during a recent visit to the facility.

The resident resided in an assisted living facility. The resident's diagnoses included hemiplegia (one-sided loss of strength or paralysis) and hemiparesis (weakness on one side of the body) related to a CVA (cerebral vascular accident/stroke) chronic obstruction pulmonary disease (COPD), and history of falls. The resident's service plan included assistance with activities of daily living as needed and medication management. The resident's nursing assessment indicated she used a wheelchair for mobility. The resident was oriented and could communicate her needs.

A concern arose when the resident had a fall but lacked nursing follow up after the incident. The resident was evaluated in the emergency room and diagnosed with a hip fracture, but surgical intervention was not warranted and the resident returned to the facility that day. The facility was not made aware of the fracture. As days went on, the resident's hip bruising worsened. A facility nurse did not assess the resident in follow-up to the fall or the increased area of bruising to the hip. There was also concern the resident's pain medication order was not appropriately filled due to lack of nursing follow up on the medication's insurance coverage and the resident did not get adequate pain relief.

An incident report indicated the resident fell off her wheelchair, unwitnessed, while reaching for something on her dresser. The caregiver notified the family member who instructed him to call 911. During this time, the caregiver tried to call another unlicensed staff member but got no answer. Vital signs were taken, and a skin tear was bandaged. A description of the injury indicated a skin tear on the right forearm and bruising to the right thigh.

The resident's progress notes indicated six days after the fall an entry was made by an unlicensed caregiver to "please keep an eye on the bruise," which was from below the groin down to the knee. Another unlicensed caregiver documented the resident was in pain and needed help with dressing and toileting.

About a week later, the progress notes indicated a regional nurse spoke to a family member after the injury and confirmed the resident was not on blood thinners and that Tylenol was scheduled and as needed for pain. Per review of the medication administration record (MAR) the increased Tylenol order was delayed as the order was not fully processed because of an insurance coverage issue and the temporary nurse in the building was unaware.

Fifteen days after the fall, the progress notes indicated a nurse wrote the resident had a large bruise status-post a fall on left inner thigh measuring approximately 25 centimeters (cm) x 10 cm., yellow around the edges and was beginning to fade. A bruise on left outer hip area that is 4 cm x 2 cm, dark purple.

During an interview, an unlicensed caregiver stated he did not contact the nurse at the time the resident's injury was discovered because he did not witness the resident fall. When he questioned the resident as to what happened, the resident explained she had fallen sometime earlier. The resident was given options as to what she wanted to do, and she asked for her family member to be contacted and was ultimately transported by ambulance to the hospital.

A temporary nurse who was onsite at the time of the investigation visit, was asked about the process to follow-up on an incident with injury and she stated nursing becomes aware when they receive and review the incident reports.

During an interview, the director stated there was a nurse employed continuously during that period of time, including a nurse at the regional level. The director stated in each case, the unlicensed caregivers should have called the nurse as well as the family member. Also, the facility was not provided with a hospital summary after the first evaluation.

The facility policy for reporting a change in condition indicated a staff member who observes or suspects a change in a resident's condition must immediately notify a licensed nurse or appropriately trained designee. The facility policy was not followed at the time the change in condition was suspected and the facility received correction orders at the time of the inspection survey.

During interview, a family member stated an unlicensed caregiver called the night of the hip injury and asked him what they should do. The family member told him to call an ambulance and take her to the hospital. The resident was evaluated, diagnosed with a hairline hip fracture and returned to the facility that day. Later that week, another caregiver called and said the resident's bruise looked concerning and had increased in size. The family member instructed them to call an ambulance and take her to the hospital. The bruise was diagnosed as hematoma, and she returned to the facility. The family member did receive a call from a regional nurse to discuss the resident's care by phone.

In conclusion, the Minnesota Department of Health determined neglect 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.

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.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30723	A. BUILDING: _____ B. WING _____	C 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANKATO LODGE SENIOR LIVING	1360 ADAMS 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 January 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL307235165C/#HL307236424M. No correction orders are issued.	0 000		