Electronically Delivered

August 27, 2025

Licensee
Bridgewater at Owatonna
125 Park Street East
Owatonna, MN 55060

RE: Project Number(s) SL34946016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 10, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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 ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34946016-0 On July 7, 2025, through July 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 48 residents; 45 receiving services under the Assisted Living Facility license.	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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 7, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of	0 620		

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0 620	Continued From page 4 known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) for an incident of potential neglect following a hospitalization for one of one resident (R1) and an incident of self-neglect/suicidal ideation for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 620		

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0 620	Continued From page 5 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: R1 R1's diagnoses included heart failure, heart disease, obstructive sleep apnea, anxiety and depression. R1's Service Plan dated June 8, 2025, included the services of bathing, medication set-up and administration, and stand-by assistance with transfers. R1's progress note dated June 27, 2025, indicated "resident returned from [hospital name] on June 27, 2025, at approximately 10AM - diagnosis of COPD exacerbation (an acute illness associated with R1's chronic obstructive pulmonary disease, or chronic lung disease). No medication changes made. Currently waiting on the hospital to fax complete discharge record." The licensee's MAARC report dated July 1, 2025, at 8:24 a.m. read, "[R1] was admitted to [hospital name] June 23, 2025. At some point she was then admitted to their ICU (intensive care unit) department but there was no communication with our facility. On 6/25, 2025, (June 25, 2025), she was ready to be discharged back to [facility name], but still did not have any communication or otherwise as to what her diagnosis was, what her baseline was supposed to be, follow-up appointments, new medications, etc. [licensee name] asked for these things in advance of her being discharged and, at the very least, to have a nurse connect with one of our	0 620		

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0 620	Continued From page 6 nurses before 10:00 a.m. on June 27, 2025, to ensure a safe discharge plan. [hospital name] discharged [R1], on the morning of June 27, 2025, without any of the necessary items in place. She did not have the new medications that were supposed to be prescribed, no follow up appointments made or communicated, and not discharge paperwork. There was not communication to [licensee name] when they discharged her. On the afternoon of June 27, 2025, [physician name] contacted [license name] to state that the patient, [R1] was discharged before receiving her new medications, her follow up appointment made and admitted that there was not discharge paperwork sent with her. [Physician name] then scrambled, looking for numbers to the pharmacy to call in the prescriptions that were missed upon discharge. [R1] ended up going back to the ER [emergency room] in [city] on June 27, 2025, due to feeling nauseous, not being able to breathe, and not feeling well overall. [Physician's name], Social Worker [name], Social Worker's Supervisor [name] fully admitted that [R1] was incorrectly discharged and that they missed a lot of steps before letting her be discharged, but no resolution was given as she was already back at the facility." On July 7, 2025, at 2:40 p.m., housing manager (HM)-C stated he filed the MAARC report following R1's hospitalization and not receiving discharge paperwork or orders from the hospital upon R1's discharge on June 27, 2025. He stated he debated about filing the MAARC report, but debated too long and should have filed it within 24 hours of the event/discharge. R2 R2's diagnoses included posttraumatic stress	0 620		

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0 620	Continued From page 7 disorder (PTSD), COPD, type 2 diabetes with neuropathy (nerve pain), and suicidal ideation. R2's Service Plan dated January 6, 2025, indicated he received services including assistance with transfers, bathing, dressing, grooming, behavior management, one to one activity, medication management/administration, safe smoking assistance, and toileting. R2's progress notes dated June 30, 2025, indicated: -10:17 a.m.- On June 29, 2025, it was reported that resident was threatening to end his life with a knife. Kitchen staff [staff name] was informed by [staff name] via phone that resident threatened to end his life. Resident proceeded outside through the dining room doors. [Staff name] followed him outside on foot then [staff name] also came outside. Resident continued towards the swine barns at the fairgrounds. [Staff name] informed [staff name] to contact 911 and then got into her vehicle to keep on eye on him until the police arrived on scene. [Staff name] stated she kept her distance and talked to resident through the window of her vehicle. Resident then held the knife up to his throat, red in the face and crying and yelled [expletive language]. [Staff name] pleaded with resident not to do anything and that we call care about him. Once resident seen that police arrived on scene, he then locked himself inside a port-a-potty at the fairgrounds. Officers finally convinced resident to come out and resident was then transported to [local emergency department] via ambulance. Resident has been admitted to [hospital name] for a 72-hour psych [psychiatric] hold. Message was left for Case Worker [name]. Attempted to contact EC [emergency contact] [name] and call was unable to go through and message not able to be	0 620		

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0 620	Continued From page 8 left. -3:07 p.m.- resident returned from the emergency department at 2:15 p.m. New order changes for duloxetine, lorazepam, quetiapine XR [extended release], quetiapine and tizanidine. R2's After Visit Summary (AVS) dated June 29, 2025, included medication changes and written guidance for signs of suicidal ideation. The licensee's MAARC report dated July 3, 2025, at 2:01 p.m. read, "When [R2] was discharged from Hospice, he refused to be seen by [primary care provider name] here at [facility name] which caused a delay with medication refills, etc. [R2] was out of a psych [psychiatric] med [medication], quetiapine from June 24, 2025, to June 27, 2025, it was on backorder due to the holdup with physician's orders, he then left the building on 28th and 29th [June 28, 2025, and June 29,2025], which appeared to cause a psychotic break with [R2]. He held a knife to his throat and threatened to kill himself. [R2] was then taken to the [local ER name] on 6/29 [June 29, 2025] and discharged on 6/30 [June 30, 2025] with a new 30 script [prescription] for this medication, but [R2] has refused it on 1st and 2nd [July 1, 2025, and July 2, 2025]. On July 7, 2025, at 2:40 p.m., house manager (HM)-C stated the events referenced on the MAARC report filed by the licensee for R2 were complex and confusing. HM-C further stated he should have filed a MAARC report immediately or within 24 hours of R2's self- neglect and suicidal ideation; however, did not make the decision to file it until July 3, 2025. The licensee failed to immediately (within 24 hours), report to MAARC, an incident of	0 620		

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0 620	Continued From page 9 suspected neglect by another provider and an incident of suicidal ideation/suicide attempt/self-neglect. The licensee's Vulnerable Adult Maltreatment policy dated July 30, 2024, indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult will report the incident immediately to the executive director [ED], registered nurse [RN] or licensed assisted living director [LALD] and that person will complete an incident report. If the incident appears to be suspected abuse, neglect or financial exploitation the ED, RN, or LALD will immediately make a report to the common entry point [CEP]. "Immediately" means as soon as possible, but no longer than 24 hours from the time the ED, RN, or LALD received initial knowledge that the incident occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	0 630		

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0 630	Continued From page 10 self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R5, R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5 R5 started receiving services on August 6, 2020, with diagnoses including heart failure, type 2 diabetes, hypertension, and hearing loss. R5's Service Plan Addendum dated May 9, 2025, indicated he received services including assistance with bathing, dressing, hearing aids, medication management/administration, compression stockings, blood sugar monitoring, and urinary catheter management. On July 8, 2025, at 12:05 p.m., unlicensed personnel (ULP)-M was observed to empty R5's urinary catheter bag and escort him to the dining room for lunch. R5's IAPP dated May 9, 2025, indicated R5 was	0 630		

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0 630	Continued From page 11 unable to manage finances and had a power of attorney to manage. Furthermore, question 19 indicated "no" as the answer to "Is the elder susceptible to abuse from other individuals including other vulnerable adults?" R6 R6 was admitted to the assisted living facility on April 23, 2025, with diagnoses including stroke with left sided weakness/paralysis, and type 2 diabetes. R6's Service Plan Addendum dated April 25, 2025, indicated she received services including assistance with bathing, dressing, grooming, transfers and ambulation, and toileting. R6's service plan lacked the services of medication management/administration and blood sugar monitoring. On July 8, 2025, at 8:05 a.m., the surveyor observed ULP-K administer seven oral medications and complete a blood sugar check for R6 at the dining room table. R6's IAPP dated May 7, 2025, indicated "no" to question 19, "Is the elder susceptible to abuse from other individuals, including other vulnerable adults?" R7 R7 started receiving services on September 21, 2020, with diagnoses including multiple sclerosis. R7's Service Plan Addendum dated January 7, 2025, indicated she received services including assistance with bathing, dressing, grooming, toileting, medication management/administration, transfers and oxygen use. R7's service plan lacked the services of chest physiotherapy vest	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

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0 630	Continued From page 12 and cough assist equipment. On July 8, 2025, at 7:35 a.m., the surveyor observed ULP-J administer two oral medications and provide R7 juice per her request. ULP-J stated staff provided total care to R7 as she had multiple sclerosis was only able to move her head and neck. R7's IAPP dated July 3, 2025, indicated R7 was unable to manage her finances and had a power of attorney to manage them. Further, R7's IAPP indicated "no" to question 19, "Is the elder susceptible to abuse from other individuals, including other vulnerable adults?" R5, R6, and R7's IAPPs lacked an accurate depiction of their susceptibility to abuse by others including other vulnerable adults, and lacked interventions to minimize the risk for abuse by others. On July 9, 2025, at 3:15 p.m., clinical nurse supervisor (CNS)-B stated all residents are vulnerable adults and susceptible to abuse because they receive services from the licensee. CNS-B stated she would need to address all residents IAPPs to accurately reflect their susceptibility to abuse by others. The licensee's Individual Vulnerable Adult policy dated July 30, 2024, indicated the individual abuse prevention plan will include: -Individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 630	Continued From page 13 days	0 630		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for three of four residents (R6, R7, R15). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01640		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

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01640	Continued From page 14 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R6 R6 was admitted to the assisted living facility on April 23, 2025, with diagnoses including stroke with left sided weakness/paralysis, and type 2 diabetes. R6's Service Plan Addendum dated April 25, 2025, indicated she received services including assistance with bathing, dressing, grooming, transfers and ambulation, and toileting. R6's service plan lacked the services of medication management/administration and blood sugar monitoring. On July 8, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-K administer seven oral medications and complete a blood sugar check for R6 at the dining room table. R6's medication administration record (MAR) dated July 2025, included medications administered by ULPs; furthermore, R6's MAR included daily blood sugar results from July 1, 2025, through July 7, 2025. R6's treatment plan dated May 7, 2025, included the treatments of Occupational Therapy and Physical Therapy; however, the plan did not include blood sugar checks.	01640		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

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01640	Continued From page 15 R6's prescriber orders dated April 18, 2025, indicated an order for "Accu-Chek (blood sugar check) twice daily." On July 9, 2025, at 3:40 p.m., clinical nurse supervisor (CNS)-B stated R6's service plan did not include medication management/administration or blood sugar monitoring, and should have. R7 R7 was started services on September 21, 2020, with diagnoses including multiple sclerosis. R7's Service Plan Addendum dated January 7, 2025, indicated she received services including assistance with bathing, dressing, grooming, toileting, medication management/administration, transfers and oxygen management. R7's service plan lacked the services of chest physiotherapy vest and cough assist equipment. On July 8, 2025, at 7:35 a.m., the surveyor observed ULP-J administer two oral medications and provide R7 juice per her request. ULP-J stated staff provided total care to R7 as she had multiple sclerosis was only able to move her head and neck. R7's MAR dated July 2025, included documentation of medications administered, monthly vital signs, daily bowel tracking, cough assist (machine used to elicit a cough response to clear secretions) twice daily, complete at least two rounds each time, and percussion vest (a vest worn to vibrate the chest wall and loosen secretions), twice daily for 30 minutes. R7's signed prescriber order dated October 7,	01640		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 16 2024, indicated high frequency chest wall oscillation, twice daily for 30 minutes. R7's signed prescriber order dated January 24, 2025, indicated Biwaze cough system, twice daily, used following chest vest percussion. R7's treatment plan dated July 3, 2025, included the treatments of bed assist device (bedrails), oxygen, nebulizer and vest compression device and cough assist device. R7's service plan did not include the percussion vest (for chest physiotherapy), and the cough assist treatment. On July 9, 2025, at 12:15 p.m., CNS-B stated the cough assist, and percussion vest were not included in R7's service plan, and should have been. R15 R15 was admitted to the facility under the facility's Assisted Living Facility (ALF) license on January 17, 2022, with diagnoses including history of stroke, history of fractures (hip/ribs), and hypertension. R15's Service Plan Addendum dated December 26, 2024, indicated she received services of medication administration, compression stocking management, assistance with bathing, dressing, transfers and toileting. R15's MAR dated July 2025, included documentation by staff for compression stockings (on in morning, off in evening), monthly vital signs, and monthly weight. R15's medications, times, and dosing were listed; however, no staff documentation was completed as R15	01640		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

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BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

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01640	Continued From page 17 self-administered her own medications. R15's progress notes dated March 28, 2025, and May 23, 2025, indicated, "nursing set up monthly medications for self-administration." R15's medication assessment for self-administration dated June 24, 2025, indicated R15 was deemed able to partially safely self-administer medications; but prefers to have staff set up medications. R15's medication plan dated June 24, 2025, indicated the licensee provided medication set up in medi-planner by the facility nurse. R15's service plan did not include the appropriate medication service of medication set-up verses staff medication administration. On July 9, 2025, at 3:00 p.m., CNS-B stated R15 self-administered her medications after the licensee's nurse completed a monthly medication set-up for her. She further stated the licensee did not administer R15's medications. The licensee's Contents of the Service Plan policy dated July 30, 2024, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. Service plans are reviewed and revised as needed based upon on-going resident assessment. Service plans will include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences	01640		

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01640	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-K) completed eye drop administration per licensee procedure for one of one resident (R12). Furthermore, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for three of three residents (R5, R6, R7) for medication administration delegated to unlicensed personnel. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01750		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

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01750	Continued From page 19 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: EYE DROP ADMINISTRATION R12 R12 was admitted to the facility on June 10, 2024, with diagnoses including chronic lymphocytic leukemia, obstructive sleep apnea, and glaucoma. R12's Service Plan dated June 23, 2025, indicated she received services to include medication administration. On July 8, 2025, at 8:47 a.m., the surveyor observed unlicensed personnel (ULP)-K set up and administer four oral medications. ULP-K then donned gloves and administered timolol 0.5% eye drops (for glaucoma), giving one drop in each eye, and within 10 seconds, administered a second glaucoma eye drop medication, brimonidine 0.2%, giving one drop in each eye. ULP-K stated she was not aware eye medications needed to be separated by a period of time for them to be effective. R12's signed medication orders dated January 27, 2025, included: -timolol 0.5 % ophthalmic solution, give one drop in each eye twice daily; and -brimonidine 0.2% ophthalmic solution, give one drop in each eye three times daily The licensee failed to wait the designated amount of time (3-5 minutes) between each eye medication to ensure the first eye drop had	01750		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01750	Continued From page 20 adequate time to "work". ULP-K's Eye drop competency dated October 24, 2024, indicated 13. If administering more than one type of eyedrop, you should wait 3-5 minutes between each type. On July 8, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-B stated the ULP are trained to wait three to five minutes when administering different kinds of eye drops to allow time for the first set of drops to work. PRN MEDICATION INSTRUCTION R5 R5 started receiving services on August 6, 2020, with diagnoses including heart failure, type 2 diabetes, hypertension, and hearing loss. R5's Service Plan Addendum dated May 9, 2025, indicated he received services including medication management and medication administration. On July 8, 2025, at 12:05 p.m., the surveyor observed ULP-M to empty R5's urinary catheter bag and escort him to the dining room for lunch. ULP-M stated R5 had already received his morning medications. R5's signed medication orders dated January 27, 2025, included one medication for the heart, one for edema (water retention), one for the thyroid, one for blood pressure, two for constipation, one for tremor, one for cholesterol, one for mild pain, one for significant pain, one for diarrhea, one oral antibiotic, one supplement, one topical antibiotic, and two topical medications for skin rash. R5's medication administration record (MAR)	01750		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

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01750	Continued From page 21 dated July 2025, included the following PRN medications: -docusate 100 milligrams (mg), give one capsule by mouth twice daily as needed for constipation; -peg 3350 17 grams (gm), give 17 gm in 4-8 ounces of fluid daily as needed for constipation; -acetaminophen tablet 325 mg, take two tablets by mouth every six hours as needed for pain; and -hydrocodone-acetaminophen 5-325 mg, give one tablet by mouth three times daily as needed for pain-do not exceed 4000 mg acetaminophen in 24 hours The licensee did not provide instruction for the ULP to understand which PRN medication for constipation should be used first, second, etc. and which PRN pain medication should be used. R6 R6 was admitted to the assisted living facility on April 23, 2025, with diagnoses including stroke with left sided weakness/paralysis, and type 2 diabetes. R6's Service Plan Addendum dated April 25, 2025, indicated she received services including assistance with bathing, dressing, grooming, transfers and ambulation, and toileting. R6's service plan did not include the services of medication management/administration and blood sugar monitoring. On July 8, 2025, at 8:05 a.m., the surveyor observed ULP-K administer seven oral medications and complete a blood sugar check for R6 at the dining room table. R6's signed medication orders dated April 18, 2025, included one medication for mild pain, two for high blood pressure, one for blood thinning,	01750		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

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01750	Continued From page 22 one topical for rash/itching, one for depression, two for diabetes, one topical pain medication, one for allergies, two for sleep, one for cholesterol, one for muscle spasms. R6's PRN medications included one for skin rash, one for diarrhea, one for nausea/vomiting, and two for constipation, one eye drop for dry eyes, R6's MAR dated July 2025, included the following PRN medications: -PEG 3350 17 gm powder, dissolve 17 gm in water and take orally daily as needed for constipation -senokot-S stool softener with laxative 50 mg-8.6 mg, take one tablet by mouth twice daily as needed for constipation. The licensee failed to provide instruction for the ULP to understand which PRN medication for constipation should be used first and second, etc. R7 R7 started services on September 21, 2020, with diagnoses including multiple sclerosis. R7's Service Plan Addendum dated January 7, 2025, indicated she received services including medication management and medication administration. On July 8, 2025, at 7:35 a.m., the surveyor observed ULP-J administer two oral medications and provided R7 prune juice per her request. R7's signed medication orders dated January 16, 2025, January 24, 2025, February 12, 2025, June 25, 2025, June 26, 2025, and June 30, 2025, indicated scheduled medications including three for high blood pressure, one for the heart, one for cholesterol, one for nerve pain, two for	01750		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01750	Continued From page 23 constipation, one for gastrointestinal upset, one for sleep, one for nausea/vomiting, one for depression, one for muscle spasms, one supplement and one nebulizer for breathing. Additionally, R7's orders indicated PRN medications including one for mild pain, four (inhaler/nebulizer) for breathing, one for diarrhea, one for the skin, four for constipation (two oral, two rectal), one for gas relief, one for heartburn, and two for cough. R7's MAR dated July 2025, included the following PRN medications: -SM fiber (Metamucil) dissolve one tablespoon in beverage and drink daily as needed for constipation; -PEG 3350 powder (MiraLAX), dissolve 17 gm in water and take by mouth daily as needed for constipation; -bisacodyl 10 mg suppository, give one suppository rectally once daily as needed for constipation; -disposable rectal enema, insert one enema rectally once daily as needed for constipation; -promethazine-DM 6.25-15 milligrams/milliliter (mg/ml), give 10 ml orally four times daily as needed for cough; -mucous relief 600 mg tablet extended release 12 hour, give two tablets by mouth twice daily as needed for cough; -ipratropium-albuterol 0.5-2.5 mg/3 ml, inhale one vial via nebulizer four times daily as needed for wheezing/shortness of breath; -albuterol 90 microgram (mcg), inhale two puffs by mouth every four hours as needed for wheezing; -ipratropium-albuterol 0.5-3 mg/3 ml, inhale 3 ml twice daily as needed for wheezing/shortness of breath; and -acetylcysteine 20%, solution, inhale 2 ml via	01750		

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01750	Continued From page 24 nebulizer four times daily as needed for breathing On July 9, 2025, at 1:35 p.m., CNS-B stated R7 had a vaginal/rectal fistula (an abnormal connection between the vagina and rectum). R7 and the ULP knew only nurses are to give rectal medications to R7. CNS-B stated the instructions were not written, just understood. The licensee failed to provide written instruction for the ULP to understand which PRN medication would be provided to R7 for symptoms of constipation, cough, or wheezing/breathing concerns. On July 9, 2025, at 3:15 p.m., CNS-B stated she would need to review all residents receiving medications from the licensee and ensure PRNs used for the same symptoms were clarified for the ULP. The licensee's Administration of Medication, Treatment, and Therapy by Unlicensed Personnel dated July 30, 2024, indicated the registered nurse (RN) has developed written, specific instruction for each resident and the RN has communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34946	A. BUILDING: _____ B. WING _____	07/10/2025

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(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
01770	Continued From page 25 administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (R15). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on July 7, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication setup. R15's Service Plan dated December 26, 2024, indicated she received medication administration. The service plan did not include the service of medication set-up services by the licensee. R15's MAR dated July 2025, indicated she received nine supplements, one oral medication for constipation, one for mild pain, one topical (on the skin) for pain, and one rectal medication for constipation. R15's progress notes dated March 28, 2025, and	01770		

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	34946	A. BUILDING: _____ B. WING _____	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

(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
01770	Continued From page 26 May 23, 2025, included entries by the nurse and indicated, "nursing set up monthly medications for self-administration." R15's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration as required. On July 10, 2025, at 10:05 a.m., CNS-B stated she and other nurses set up medications for two residents and only documented in the resident progress notes when the nurse set up medications in medi-sets, and she did not document what medications, quantity of dose, times, or route. CNS-B stated she had a different practice when she worked at a different assisted living facility (ALF) and used a printed-out medication sheet to document medication set-up; however, when she started with this licensee, the practice was to only write a monthly progress note indicating the medications were set up and she continued that practice. She further stated the progress notes lacked the required content. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

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01890	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure stored medications were not expired for two of 45 residents (R5, R8) with medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). R5 R5's Service Plan dated May 9, 2025, indicated R5 received services including medication administration, R5's signed prescriber's orders dated January 27, 2025, included triamcinolone 1% cream, apply 2 grams twice daily as needed for rash. On July 8, 2025, at 8:55 a.m., the surveyor reviewed the contents of the licensee's medication carts and noted R5's triamcinolone topical cream expired on April 18, 2025. R8 R8's Service Plan dated March 20, 2025, indicated R8 received the service of medication management/administration. R8's signed provider orders dated January 27, 2025, indicated docusate sodium 100 milligrams (mg), give one capsule orally twice daily as	01890		

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BRIDGEWATER AT OWATONNA	125 PARK STREET EAST OWATONNA, MN 55060

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01890	Continued From page 28 needed (PRN) for constipation. On July 8, 2025, at 8:55 a.m., the surveyor reviewed the contents of the licensee's medication cart and noted R8's docusate had an expiration date of April 23, 2025. The licensee failed to ensure R5 and R8's medications had not exceeded the expiration date. On July 8, 2025, at 10:50 a.m., clinical nurse supervisor (CNS)-B stated the nurses reviewed the medication cart contents on a regular basis and was not sure how the expired medications were missed. The licensee's Storage of Medications policy dated July 30, 2024, indicated medications will be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided	01960		

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01960	Continued From page 29 to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed for two of four residents (R6, R7) with treatments. Furthermore, the licensee failed to document oxygen flow rate used by one of one resident (R7) with oxygen use. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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: R6 R6 was admitted to the assisted living facility on April 23, 2025, with diagnoses including stroke with left sided weakness/paralysis, and type 2 diabetes. R6's Service Plan Addendum dated April 25, 2025, indicated she received services including assistance with bathing, dressing, grooming, transfers and ambulation, and toileting. R6's service plan lacked the services of medication management/administration and blood sugar monitoring. R6's prescriber orders dated April 18, 2025, included blood sugar checks (Accu-Chek's) twice	01960		

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01960	Continued From page 30 daily. On July 8, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-K administer seven oral medications and complete a blood sugar check for R6 at the dining room table. R6's medication administration record (MAR) dated July 2025, indicated blood sugar checks were completed daily. The licensee failed to provide the treatment of blood sugar checks twice daily per prescriber orders. On July 9, 2025, at 3:20 p.m., clinical nurse supervisor (CNS)-B stated she was not sure why the licensee was completing the blood sugar daily and not per the signed provider's order for twice daily. R7 R7 was started services on September 21, 2020, with diagnoses including multiple sclerosis. R7's Service Plan Addendum dated January 7, 2025, indicated she received services including oxygen management. On July 9, 2025, at 1:30 p.m., the surveyor and CNS-B observed R7 in her apartment. She was in bed with oxygen on via nasal cannula. R7 stated she thought the oxygen was set at three liters. The surveyor and CNS-B observed an oxygen concentrator in the room with a flow rate of 2.5 liters/minute. R7 stated she used supplemental oxygen at night and also during the day when she napped.	01960		

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01960	Continued From page 31 R7's after visit summary (AVS) dated January 24, 2025, indicated oxygen at 1 liter/minute continuously. R7's provider note dated April 22, 2025, indicated R7 was using oxygen at 2 liters/minute limited to overnight use. R7's Services Received Record dated July 1, 2025, through July 9, 2025, indicated oxygen (O2) assist twice daily (morning and evening). The licensee failed to document R7's oxygen flow rate (liters/minute) as provided when used for sleep, and R7's record lacked documentation of midday or as needed (PRN) oxygen use. Furthermore, the licensee failed to ensure R7's oxygen flow rate was set as ordered. On July 9, 2025, at 1:40 p.m., CNS-B stated there was no flow rate indicated on R7's Services Received Record, and further stated she was unable to find a current order to provide oxygen at 2.5 or 3 liters/minute. She further stated R7's Services Received record lacked the prescribed oxygen flow rate or documentation of the flow rate as set by the ULP or requested by R7. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated reviewed July 30, 2024, included: 2. Medications, treatment, and therapy always need to be administered according to the "6 Rights" a. right person b. right medication, treatment, or therapy c. right time d. right route (by mouth, eye drops, to the skin, etc.)	01960		

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01960	Continued From page 32 e. right dose (how many milligrams, drops, etc.) f. right chart/record to document that the medication, treatment, and therapy was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of four residents (R7) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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).	01970		

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01970	Continued From page 33 The findings include: R7 began receiving services on September 21, 2020, with diagnoses including multiple sclerosis. R7's Service Plan Addendum dated January 7, 2025, indicated she received services including assistance with bathing, dressing, grooming, toileting, medication management/administration, transfers, and oxygen management. R7's service plan lacked the services of chest physiotherapy vest and cough assist equipment On July 9, 2025, at 1:30 p.m., the surveyor and clinical nurse supervisor (CNS)-B observed R7 in her apartment. She was in bed with oxygen on via nasal cannula. R7 stated she thought the oxygen was set at three liters. The surveyor and CNS-B observed an oxygen concentrator in the room with a flow rate of 2.5 liters/minute. R7 stated she used supplemental oxygen at night, and also during the day when she napped. R7's after visit summary (AVS) dated January 24, 2025, indicated oxygen at 1 liter/minute continuously. R7's provider note dated April 22, 2025, indicated R7 was using oxygen at 2 liters/minute limited to overnight use. R7's Services Received Record dated July 1, 2025, through July 9, 2025, indicated oxygen (O2) assist twice daily (morning and evening). The record/documentation did not indicate a flow rate or as needed (PRN) use. The licensee failed to ensure an updated order for R7's current oxygen use was obtained.	01970		

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01970	Continued From page 34 On July 9, 2025, at 1:40 p.m., CNS-B stated she could not find any updated order for oxygen at the current flow rate of 2.5 - 3 liters/minute. The licensee's Medication and Treatment and Therapy Orders policy dated July 30, 2024, indicated all medication and treatments will have an appropriate prescriber order in the resident's record. - A licensed nurse will be updated on the receipt of all orders in a timely fashion. - All medication and treatment orders will be renewed by a prescriber annually or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in	02410		

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02410	Continued From page 35 the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide privacy for R6 during a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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: On July 8, 2025, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-K set up R6's blood sugar testing supplies at the medication cart next to the main dining room. ULP-K approached R6 seated at the dining room table while waiting for breakfast. The surveyor observed three other individuals also seated at the dining room table. ULP-K stated she needed to check R6's blood sugar. R6 held out her hand on the table allowing the procedure. Another resident stated, "Let's bet on her blood sugar today." ULP-K proceeded to poke R6's finger,	02410		

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02410	Continued From page 36 obtain a drop of blood, and place it on the test strip in the monitor. ULP-K read the blood sugar results aloud. ULP-K returned the blood sugar testing equipment to the medication cart and documented R6's blood sugar results. On July 8, 2025, at 8:10 a.m., the surveyor asked ULP-K if she often checked blood sugar results in the dining area with other residents present. ULP-K stated she and other staff did complete blood sugar testing sometimes when the residents came to the dining room and were not in their apartments. On July 8, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-E stated R6 was adamant about "getting her dining room spot and not moving" prior to meals. They further stated R6 had not expressed concern with completing this treatment at the dining room table in from of other residents. CNS-B and LPN-E stated they had not considered whether others (residents or visitors) at the table would be uncomfortable seeing a blood sugar check being completed in front of them. They stated they would meet with R6 and determine a means to ensure privacy for this treatment. ULP-K's blood sugar procedure competency dated October 24, 2024, indicated: - Provide privacy for the resident by closing doors and window coverings as needed No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410		

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Bridgewater at Owatonna
125 Park St E
Owatonna, MN 55060
Steele County
Parcel:

Phone:
nwinterlin@bridgewatermn.net

License Info

License: HFID 34946

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8044251065
Inspection Type: Full - Single
Date: 7/7/2025 Time: 12:41:55 PM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 3-500A Microbial Control: cooling
3-501.15A *Priority Level: Priority 2 CFP#: 33*
MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.
COMMENT: Foods cooled in deep plastic containers.

Foods moved to shallow metal pans while on site.
Comply By: 7/7/2025 Originally Issued On: 7/7/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: Foods in upright cooler in kitchen and storage room measured above 41 degrees F. See temperatures for details.

Unit temperature turned down while on site.
Comply By: 7/7/2025 Originally Issued On: 7/7/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: Unable to locate chlorine test kit.
Comply By: 7/14/2025 Originally Issued On: 7/7/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.115B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805B Discontinue using a sanitizer concentration that exceeds the EPA approved manufacturer's label amount.
COMMENT: Sanitizer in wiping cloth bucket measured at 500 ppm.

Dilute with water to 400 ppm until dispenser is repaired.
Comply By: 7/7/2025 Originally Issued On: 7/7/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: Sign not posted in men's restroom.
Comply By: 7/7/2025 Originally Issued On: 7/7/2025

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Deb Jacobson. Inspection report reviewed on site with Nate Winterlin, Executive Director.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F8044251065 from 7/7/2025

Nate Winterlin
Executive Director

Michael DeMars,
Public Health Sanitarian III
michael.demars@state.mn.us