

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL296908922M
Compliance #: HL296902283C

Date Concluded: April 13, 2026

Name, Address, and County of Licensee

Investigated:

Prairie Senior Cottages of Albert Lea
1602 Fountain Street
Albert Lea, MN 56007
Freeborn County

Facility Type: Assisted Living Facility with
Dementia Care (ALFDC)

Evaluator's Name: Christine Bluhm, 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: The facility neglected the resident when it failed to respond to the resident's change in symptoms and possible urinary tract infection which led to catheter occlusion for two days and hospitalization.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The facility followed provider's orders for catheter irrigation, contacted the provider for symptoms of infection and collected a sample for urinary testing. When the resident had no urinary output overnight, a catheter change was attempted. The resident was hospitalized, treated with continuous bladder irrigation (CBI) and antibiotics and returned to the facility at his baseline.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, related facility policy and procedures. Also, the

investigator observed the care team provide catheter care for the resident during a recent visit to the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, atrial fibrillation, history of stroke and a foley catheter for urinary retention. The resident's service plan included medication and catheter care management as well as assistance with all activities of daily living. The resident's assessment indicated for mobility he used a wheelchair. The resident was alert and verbal but confused and required redirection.

A concern arose one morning when the resident was found pale, had a distended abdomen, and his catheter had been occluded for two days. Home care nursing attempted a catheter change. During removal of the catheter, a large amount of dark blood and pus drained out of the urethra. The resident was sent to the emergency room for evaluation.

An incident note indicated the resident had uncontrollable bleeding from the urethra following catheter removal performed by the home health nurse. 911 was called and the resident was transferred to the hospital.

Nursing progress notes indicated that morning the resident had no output "since last night." The facility nurse requested a home health nurse make a visit to change out the resident's catheter. During the catheter removal, a significant amount of blood drained and bleeding could not be controlled so 911 was called. Progress notes indicated that nine days prior, the resident's urine had a "very foul odor" without other symptoms. When the resident showed increased confusion, nursing requested a visit from the provider and orders were placed to collect a urine sample. At that time, the facility nurse could irrigate the catheter without difficulty but there was a large amount of sediment. An antibiotic order for a UTI was not received until the morning the resident was transferred to the hospital.

The resident's service delivery record indicated the last measured urine output was the in the previous afternoon and the resident emptied it twice during the night, but it was not measured.

The resident's medication record indicated he was on a blood thinning medication.

The resident's hospitalization summary note indicated the resident was admitted for urinary retention and treated with continuous bladder irrigation (CBI) for hematuria (blood in urine) and intravenous fluids for acute kidney injury (AKI). Antibiotics were started for urinary infection. Bladder imaging showed a partial occluded urethra with chronic bladder wall thickening. The resident returned to the facility with continued antibiotic orders with recommendations to follow up with outpatient urology for recurrent UTIs.

During an interview, a nurse manager stated the resident's lack of output started the evening before and supported by the documentation and per staff report. The nurse stated the need for catheter irrigations have increased over the last year.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: Resident was unable to discuss the incident.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: No action required.

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: 29690	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/20/2026
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NAME OF PROVIDER OR SUPPLIER PRAIRIE SENIOR COTTAGES OF AL	STREET ADDRESS, CITY, STATE, ZIP CODE 1602 FOUNTAIN STREET ALBERT LEA, MN 56007
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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
0 000	<p>Initial Comments</p> <p>On February 20, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL296902283C/#HL296908922M. No correction orders are issued.</p>	0 000		

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