Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305802822M
Compliance #: HL305804964C

Date Concluded: July 31, 2025

Name, Address, and County of Licensee Investigated:
Prairie Cottages of Owatonna
150 24th Street NE
Owatonna, MN 55060
Steele County

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

Evaluator's Name: Lena Gangestad, 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):
Facility staff (unlicensed personnel) neglected the resident when staff failed to report a fall and the resident was found deceased two hours later.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although a fall went unreported and the resident was later found deceased, there was not a preponderance of evidence to determine that the fall contributed to the resident's death.

The investigator conducted interviews with administrative staff and a family member of the resident. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules, and facility policies, and procedures.

The resident resided in an assisted living secured memory care facility. The resident's diagnoses include hypertension, congestive heart failure, chronic kidney disease, and dementia. The resident's service plan included assistance with all activities of daily living. The service plan also included hourly safety check and repositioning every 2 hours when in bed.

The staff schedule indicated that unlicensed personnel (ULP) #1 worked the night shift and ULP #2 worked the morning shift.

Documentation indicated that the resident was found on the floor by ULP #1 and was assisted back into bed by ULP #1 and #2 at 6:00 a.m. The resident had slid out of bed, and no injuries were noted at that time. A third ULP entered the resident's room at 8:00 a.m. later that morning to administer medications and found the resident unresponsive, blue in color, with his mouth open.

The death certificate indicated that the cause of death was congestive heart failure and hypertension.

Internal investigation documentation included a statement from ULP #1, who indicated that he heard beeping and went to check on the resident. He saw the resident leaning against the bed and then asked ULP #2 to help him return the resident to bed, then rushed to assist another resident. ULP #2's statement indicated that he received a call from ULP #1 asking for assistance in helping the resident off the floor. Upon entering the room, he saw the resident sitting on the floor, moaning, but appeared to be okay. ULP #2 indicated that it seemed the resident had slid onto the floor. Both ULP helped the resident back into bed before ULP #2 returned to his designated work area and assumed ULP #1 would complete the incident report and notify the nurse.

During an interview, management staff stated that she received a call notifying her that the resident had passed away. She said she spoke with staff and learned that the resident had slid out of bed and was found on the floor beside his bed. She questioned ULP #1 and #2, who admitted they each assumed someone else would report the incident, but neither did. Management indicated ULP #1 and #2 were terminated for failing to follow fall protocol.

During an interview, the resident's family member stated the facility called her every time the resident fell and kept her updated on the day he passed. She said she did not believe the fall he had the night he died was what caused his death as he had a long history of heart failure along with several other health issues.

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: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Unlicensed Caregivers #1 and #2 were terminated for failing to follow fall protocol.

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
	30580	A. BUILDING: _____ B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE COTTAGES OF OWATONNA LLC	150 24TH STREET NE 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 On June 10, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL305802822M/HL305804964C . No correction orders are issued.	0 000		