Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306063040M
Compliance #: HL306062885C

Date Concluded: September 13, 2024

Name, Address, and County of Licensee Investigated:
Prairie Senior Cottages
113 South Ash Street
New Richland, MN 56072
Waseca County

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

Evaluator's Name: Lisa Coil, RN, BSN
Special Investigator

Finding: Substantiated, individual responsibility

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):
The alleged perpetrator neglected the resident when the alleged perpetrator did not complete rounds according to the resident's care plan. The resident fell and laid on the bathroom floor for an unknown length of time. The resident obtained a bruise to the right eye, an abrasion to the upper right cheek bone, and was unresponsive. The resident was sent to the emergency room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator, who was an unlicensed caregiver, was responsible for the maltreatment. The alleged perpetrator did not follow the residents plan of care and the resident's safety checks were not completed. The resident fell on her bathroom floor and laid for an unknown length of time. When the resident was found, she was unresponsive. The resident was transferred to the emergency room for evaluation.

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

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's. The resident's service plan included routine safety checks for risk of falls. The resident's assessment indicated the resident had memory problems and was disoriented. The assessment indicated the resident had balance problems while standing, was unsteady at times, and used a walker. The assessment also indicated the resident was independent when using the bathroom but needed assistance with cleanliness following use of the bathroom two times per shift.

The incident report indicated the resident was found unresponsive on the bathroom floor early one morning and 911 was called. The report indicated the resident was not checked on during the scheduled safety checks and it was unknown when the last time a safety check was done prior to the fall. The report further indicated facility cameras were viewed.

The services delivery record indicated the alleged perpetrator signed off overnight tasks as completed such as "delegated tasks," "fall prevention/safety checks," and "transfers/ambulation/mobility," at 8:19 p.m. the evening prior to the incident. Two other tasks, "record – bowel movement," and "toileting," were signed off as completed by the alleged perpetrator at 4:53 a.m. the morning of the incident.

The alleged perpetrator's time punches indicated the alleged perpetrator punched in at 2:52 p.m. the day prior to the incident and punched out at 6:11 a.m. morning of the incident.

The facility internal investigation file included documentation indicating the facility camera review showed no one entered the resident's room during the night shift to check on the resident. The file also included a handwritten document from the alleged perpetrator which indicated he checked the resident twice during the night. The AP also indicated he thought he checked the resident on the last round as normal routine but may have been sidetracked and asked another staff member to do it.

During an interview, an unlicensed caregiver, stated the facility staff two caregivers on the overnight shift who then split the residents in half for cares and the AP's half included the resident the night of the incident. The unlicensed caregiver stated safety checks were scheduled every two hours on every resident. At around 11:00 p.m. both of them heard a loud "bang" noise so the unlicensed caregiver checks on all their assigned residents and a few of the alleged perpetrator's assigned resident, but not the resident identified in the incident. Unlicensed caregiver assumed the alleged perpetrator checked on the rest of his assigned residents. Unlicensed caregiver stated everything was fine and the shift continued as normal. When asked if the alleged perpetrator asked for any help that shift, the unlicensed caregiver stated no.

Unlicensed caregiver stated “no” when asked if they told the alleged perpetrator they had checked on the resident identified in the incident on the night of the incident.

During an interview, a manager stated when they were told the resident was found on her bathroom floor, they sent a text message to both overnight staff to ask when the resident was last checked on. The manager stated when the alleged perpetrator responded, he indicated around 4:00 - 4:30 a.m. The manager stated the internal investigation included a review of the night shift footage and it did not show anyone entered the resident’s room the entire shift.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, attempted but unable to related to diagnoses.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, declined.

Action taken by facility:
The facility investigated the incident and sent the resident to the hospital. The employee was suspended during investigation and was no longer employed at the facility at the time of the investigation.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the

Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Waseca County Attorney
New Richland City Attorney
New Richland Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30606	A. BUILDING: _____ B. WING _____	C 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SENIOR COTTAGES OF NEW RICHLAND	113 1ST STREET SW NEW RICHLAND, MN 56072

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL306062885C/#HL306063040M On August 29, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 14 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued for #HL306062885C/#HL306063040M , tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Please see public report for details.	