Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306067563M
Compliance #: HL306063023C

Date Concluded: February 24, 2025

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

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

Evaluator's Name: Julie Serbus, 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):
The facility neglected the resident when it did not seek immediate medical attention for a critical low lab result.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While it was true there was a delayed communication of a critical laboratory value, the facility took appropriate actions when it became aware of the results.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident record(s), progress notes, provider notes, and related facility policy and procedures. The investigation included an onsite visit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included traumatic brain injury, multiple mental health disorders, and iron deficiency. The resident's service plan indicated unlicensed caregivers were report to nursing when there is an absence of bowel movements in a three-day period or loose stools. Bowel movements are recorded by caregivers in the resident's chart. The resident's assessment indicated nursing would notify the medical provider with concerns.

A concern arose when the resident's blood draw with laboratory results which indicated a critically low hemoglobin level. The result was sent in the afternoon to the facility but was not acted upon until the next morning when the resident was transferred to the hospital where he was diagnosed with a gastrointestinal bleed.

The resident's medical record indicated the medical provider had previously ordered routine blood work, which included a hemoglobin check. The blood draws themselves were performed by an outside agency, which came to the facility on a monthly basis. The blood draws were performed in the morning and the samples go to an outside laboratory, which subsequently sends the results to the medical provider's office. Later that afternoon, the medical provider posted the laboratory results in a medical portal (an electronic communication between the medical provider and the facility) along with a message the resident should be seen in the emergency department for a possible blood transfusion and for workup to determine the reason for the decreased hemoglobin. This same message indicated at some time later in the day the provider faxed the results to the facility and left a voice message at the facility.

Approximately two weeks prior to these events, the medical providers notes indicated had an annual wellness visit with no concerns reported in the past month with the resident's health and the routine labs were ordered at that time.

Approximately one month prior to these events, the facility's records for monitoring the resident's bowel movements indicated he had one occasion of a large black stool [which can be indicative of gastrointestinal bleeding].

The resident's medical provider order included an order for low daily dose of aspirin that was enteric (barrier applied to oral medication that prevents protect the stomach from the acidity) coated with no other blood thinners listed.

During an interview, nurse #1 stated the medical provider ordered routine labs to be drawn and she was aware of the lab draw date, however she was not in the facility that day. Nurse #1 stated the medical provider called her early the next morning on her personal cell prior to her work shift who told her about the critical lab value and the need to send the resident to the emergency room. Nurse #1 stated the resident had not been showing symptoms of low hemoglobin except a month earlier a caregiver documented on one occasion the bowel movement had been black.

During an interview, nurse #2 stated she was not at the facility the day of the lab draw. Nurse #2 stated results of labs are entered into the portal by the provider, but the portal can only be accessed by nursing at the facility. The results of the lab work were not placed into the portal until late afternoon and no notifications were sent to her email.

During an interview, a manager stated nursing at the facility would have received the results over the resident's medical portal. The manager stated nursing were not in the facility that day due to working shifts over the weekend. The manager stated nurse #1 would not have specifically watched the labs since they were ordered as routine.

During an interview, the medical provider stated the resident's hemoglobin is generally checked every six months. The medical provider stated this was an isolated event and, after this happened, the facility and the clinic had clarified the communication plan.

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
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: Updated facility voicemail message to notify nursing directly in there is an urgent need and provides the nurse phone number in the message.

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
	30606	A. BUILDING: _____ B. WING _____	C 01/30/2025

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 On January 30, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306063023C/#HL306067563M. No correction orders are issued.	0 000		