Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203153185M
Compliance #: HL203152298C

Date Concluded: July 8, 2026

Name, Address, and County of Licensee Investigated:
Ecumen Prairie Lodge
6001 Earle Brown Drive
Brooklyn Center, MN, 55430
Hennepin County

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

Evaluator's Name:
Lacey Eggersdorfer, RN, Special Investigator

Finding: Inconclusive

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 abused the resident when staff moved the resident's wheelchair out of reach, restricting her ability to self-transfer and move about freely.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. The investigation was unable to demonstrate that the wheelchair was moved at night or that moving it was to punish or restrain the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff, as well as the resident's family. The investigation included review of the resident records, facility incident reports, facility grievances, personnel files, staff schedules, related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral palsy (a lifelong neurological disorder that permanently affects body movement and coordination). The resident's assessment indicated she was alert and oriented, and was a high fall risk. The resident stood independently but could not walk. The resident's service plan included standby assistance with transfers. The service plan did not indicate staff were to move the resident's wheelchair out of reach while the resident was in bed.

Review of the resident's progress notes indicated that a meeting occurred with facility staff and the resident regarding the resident's frequent falls at night due to nighttime medication that made her drowsy. The facility implemented the administration of the resident's evening medications closer to the resident's preferred bedtime. The resident agreed to the intervention. The nursing progress note did not indicate the resident's wheelchair was to be moved out of the resident's reach after being transferred into bed to prevent her from self-transferring while drowsy.

Review the resident's progress notes following hospital discharge indicated the resident endorsed feeling weaker and dizzy upon returning to the facility. The facility encouraged the resident to utilize her call light for assistance instead of self-transferring. The resident progress note did not indicate the resident's wheelchair had to be moved out of reach to prevent self-transferring.

Review of the resident's home care notes indicated the resident had problems with wheelchair accessibility at night. The notes indicated the resident was concerned about the guidelines in place by the facility and was considering moving to a different facility.

During an interview, an unlicensed staff member stated the facility told night shift staff to ensure the resident was in bed overnight and to move her wheelchair across the room to prevent self-transferring.

During and interview, the manager stated the resident struggled with falls at nighttime due to being drowsy while in her wheelchair. She stated the resident did not struggle with self-transferring out of bed. The manager stated the resident's wheelchair remained in her reach during the night and denied instructing staff to move the wheelchair to force her to utilize her call light for assistance.

During an interview, the resident's family member stated the resident was very vocal in advocating for herself. The family member stated the resident had never told them facility staff moved her wheelchair out of reach at night.

The resident had since passed away and was unable to be interviewed.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, resident deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken

Action taken by the Minnesota Department of Health:
Insert appropriate action from standard language document

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
	20315	A. BUILDING: _____ B. WING _____	C 06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

(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 6/15/2026, the Minnesota Department of Health initiated an investigation of complaints #HL203152298C/#HL203153185M and HL203152953C/#HL203153536M. No correction orders are issued.	0 000		