Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203153536M
Compliance #: HL203152953C

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: 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 alleged perpetrators (AP) #1 and AP #2, neglected the resident when they delayed care by staging the scene after the resident fell, sustained an injury, and passed away.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. AP #1 and AP #2 responded to the resident's call for help immediately in accordance with their training and policy. In multiple reports the resident was observed to be in her wheelchair at the time of the injury. There was no evidence the resident had fallen.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed a medical examiner, as well as a home care agency. The investigation included review of the resident records, home care records, death record, hospital records, facility internal investigation, facility incident reports,

related facility policy and procedures, personnel files, staff schedules, law enforcement report, and emergency medical services report.

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) and lymphedema (a chronic condition causing swelling typically in the arms or legs). The resident's assessment indicated the resident could stand independently but was unable to walk, and used a powered wheelchair for mobility. The resident's service plan included assistance with toileting, showering, and transferring.

An internal investigation report indicated AP #1 heard the resident shout for help. AP #1 went to the residents bathroom and found her sitting in her electric wheelchair bleeding significantly. The resident was in distress and unable to say what happened. AP #1 called AP #2 for assistance, followed by 911. AP #1 and AP #2 requested the resident back her powered wheelchair out of the small bathroom so they could see where the resident was bleeding from. The resident was able to back her powered wheelchair out of the bathroom, and AP #2 tied towels around the residents bleeding left leg wound. When emergency services arrived the resident became unresponsive. She was transported to the hospital where she passed away.

A call light (used by the resident to summon assistance) record indicated the resident did not push her call light at the time of her injury.

An emergency medical services report indicated they were dispatched approximately 3 minutes after AP #1 reported hearing the resident shout for help. The emergency medical services report indicated the resident was observed to be sitting upright in her wheelchair with towels tied around her left leg wound. The report did not indicate the resident fell.

A police report indicated the police arrived at approximately the same time as emergency medical services. Police noted the resident was sitting upright in her wheelchair and placed a tourniquet on the resident's left leg. The police report included photos of the resident's bathroom as well as other areas of her room. Blood was shown on the bathroom floor with treadmarks similar to a wheelchair that led outside the bathroom. The photos did not indicate the resident was lying on the floor in the pool of blood. The photos did not indicate AP #1 or AP #2 staged the scene.

AP #1 and AP #2's personnel file indicated they were trained in response to resident emergencies. Training included basic first aid for residents that are bleeding until emergency medical services arrived.

During an interview, AP #1 stated that she heard the resident call for help and immediately went to her aid. She stated she saw the resident in the bathroom sitting upright in her wheelchair and observed a large amount of blood pooling on the floor. AP # 1 called AP # 2 for assistance and 911. AP #1 stated the resident backed her wheelchair out of the bathroom

where they saw she was bleeding profusely from her leg. She stated that she looked around the area to determine what injured the resident, and could not find anything. AP #1 denied that she witnessed the resident injuring herself.

During an interview, AP #2 stated while she applied pressure to the resident's wound, she attempted to calm the resident down and reassure her. AP #2 also stated that she tried to keep the resident awake until emergency services got there.

During an interview, a medical examiner stated the resident had abnormal blood vessels in her legs due to her past medical history. A medical examiner stated this made the resident more susceptible to heavy bleeding from an injury.

During an interview, a family member stated she was concerned about the circumstances surrounding the resident's passing. She stated that the resident had a history of falls, but needed assistance off the floor in previous instances.

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, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrators interviewed: Yes

Action taken by facility:
The facility called 911 and internally investigated the incident.

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
	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		