Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305916562M
Compliance #: HL305915682C

Date Concluded: January 5, 2026

Name, Address, and County of Licensee Investigated:
Elmhurst Commons Apartments
400 3rd Street SW
Braham, MN 55006
Isanti County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
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 neglected the resident when the resident had a fall and was found hours later alone in her room, family transported her to the hospital and the resident died nine days later from bleeding in the brain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility staff assisted the resident after the fall and 911 was called. The resident refused to go to the hospital and was later found by family with a change in condition. Although the staff did not identify the resident's change in condition after the fall it could not be determined if a delay in care would have changed the resident's outcome. The resident had a history of cerebral amyloid angiopathy (a common, age-related condition where amyloid proteins build up in brain blood vessels, weakening them and causing leaks or bleeds, leading to cognitive decline, microbleeds, or strokes) which was the cause of her death.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record(s), death record, hospital records, facility incident reports, personnel files, staff schedules and related facility policy and procedures. Also, the investigator observed the facility physical plant, medication administration, treatment administration, care being provided and staff interactions with the residents.

The resident resided in an assisted living facility. The resident's diagnoses included Lewy Body Dementia and cerebral amyloid angiopathy. The resident's service plan included assistance with bathing, medication management, weekly vital signs, monitoring behaviors, housekeeping and laundry. The resident's assessment indicated the resident was orientated to person, place and time. The resident's assessment indicated the resident was independent with ambulation, transfers, used a walker for mobility and had a history of falls. The assessment also indicated the resident would keep to herself when feeling annoyed or irritation but was able to verbalize her feelings.

Medical records indicated the resident summoned staff with her call light and staff answered in under one minute. The resident had lost her balance while ambulating and fell. After the fall the resident complained of right sided head pain and staff called 911. Emergency personnel arrived, assisted in lifting the resident off the floor, assessed and recommended the resident be sent to the hospital for evaluation but the resident refused to go to the hospital. Later, facility staff took the resident to the bathroom and administered medications at the end of the shift. Facility staff notified the nurse and family of the fall in the morning before leaving the shift.

Medical records indicated the next shift staff observed that the resident did not speak during morning cares, but they were able to administer the resident's lunch time medications. A family member called the resident who could not speak clearly. A family member arrived at the facility and found the resident's speech could not be understood and she was not able to ambulate, so family transported the resident to the hospital.

Hospital records indicated while at the hospital emergency room the resident's appeared to have no trauma on her head, but she could not answer simple questions or nod her head. The resident was diagnosed with bleeding on the brain and had a stroke. The hospital records indicated the change in condition was "most likely" related the cerebral amyloid angiopathy diagnosis from 3 months prior and was not from the trauma related to the fall. The resident was transported via ambulance to another hospital that specialized in the diagnosis, placed on comfort cares, then a week later transported to a group home for hospice support where two days later she died.

The death report indicated the resident died from intraparenchymal hemorrhage (bleeding directly into the brain's functional tissue) of brain due to cerebral amyloid angiopathy.

During an interview, unlicensed personnel #1 stated the resident was able to communicate after the fall and was able to point to the back of her head. Unlicensed personnel #1 stated the resident's speech was clear and did not appear to have any other injury. Unlicensed personnel #1 stated the resident was talking normally after the fall and was able to communicate with the emergency personnel that she did not want to go to the hospital. Unlicensed personnel #1 stated she observed the resident sign a document for the emergency personnel that indicated the refusal not to be transported and informed emergency personal that she would call a family member. Unlicensed personnel #1 stated later that shift, unlicensed personnel #1 checked on the resident and recalled the resident telling her she was "ok" and administered the resident's medication toward the end of her shift. Unlicensed personnel #1 stated she called the resident's family member at the end of the shift to report the resident lost her balance, fell and hit her head. Unlicensed personnel #1 did not recall informing the family member the time of the fall. Unlicensed personnel #1 stated she called facility administration, who is also a nurse, to report the fall before leaving work.

During an interview, unlicensed personnel #2 stated the next shift while she was putting the resident's sweater on, the resident was in her wheelchair and did not speak, like the resident was perhaps confused but recalled the resident had a history of behaviors. Unlicensed personnel #2 stated the resident usually complained of pain but did not speak nor did she recall the resident eating breakfast or lunch that day. Unlicensed personnel #2 stated she reported the behavior to facility administration and documented in the resident's medical records.

During an interview, unlicensed personnel #3 stated she stopped by the resident's room to say hello. When she entered the resident's room the resident was digging in a candy drawer, was all "smiles," had her arms out and just wanted a lot of hugs but did not speak. the resident's room approximately two to three minutes. unlicensed personnel #3 recalled the resident would normally talk to staff.

During an interview, a facility nurse stated when the resident fell the staff called 911 and the resident refused to be seen in the emergency room. The family wasn't notified when the fall occurred because the resident was her own person however the family was notified later that morning. The nurse was notified by the staff about the fall. A facility nurse stated later that afternoon staff reported the resident was going in to be seen at the hospital with family for foot pain. The nurse denied knowing the resident hit her head, had pain from the fall or had a change in her speech.

During an interview, administrative personnel stated 911 was notified and emergency personnel came and looked the resident over and got her off the floor. Unlicensed personnel did not report the fall until later that morning because the resident had been looked over by emergency personnel and the resident refused to be seen in the emergency room. The resident received her scheduled services after the fall and no concerns were reported from staff. The administrative personnel stated the resident would fall and request the family member not be notified because she said he was busy.

During an interview, a family member stated a staff nurse called to notify the resident fell in the morning, that the resident refused to go to the hospital and was “ok.” A family member stated he called the resident and could not understand her speech, then proceeded to go to the facility where he found the resident alone in her room, the resident could not talk or walk. A family member stated he thought the resident had a stroke and took her to the hospital where she had x-rays to her head. A family member stated the resident was diagnosed with “microbleeds” in her head approximately three months prior to fall #3. A family member recalled the “microbleeds” were not treated at that time due to the side effects of the treatment.

In conclusion, the Minnesota Department of Health determined neglect 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.

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 Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility responded to the resident’s call light after the resident fell.
The facility assessed the resident and called 911.
The facility completed an incident report.

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
	30591	A. BUILDING: _____ B. WING _____	C 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMHURST COMMONS APARTMENTS	400 3RD STREET SW BRAHAM, MN 55006

(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 December 2, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL305915682C/#HL305916562M. No correction orders are issued	0 000	Assisted Living Provider 144G. 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.	