Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL311293482M
Compliance #: HL311296607C

Date Concluded: July 23, 2025

Name, Address, and County of Licensee Investigated:
Autumn Glen Senior Living
3715 Coon Rapids Blvd. NW
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name: Lori Pokela, 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 the facility was not appropriately staffed, and staff did not follow the plan of care resulting in falls and development of blisters on the resident's buttocks.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff followed the resident's plan of care and there was no record of skin concerns noted on the resident. Following each fall, the resident was assessed and monitored and sent for further evaluation if needed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), facility incident reports, personnel files, staff schedules, and related facility policy and

procedures. Also, the investigator observed the facility environment, medication and treatment administration, cares being completed and staff interaction with the residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's Disease, chronic kidney disease and thrombophlebitis (inflammation of a vein, often caused by a blood clot (thrombus). The resident's service plan included assistance with dressing, grooming, medication management, escorts to the dining room, and laundry. Safety checks were also included on the resident's service plan to be completed at: 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., and 10:00 p.m. The resident's assessment indicated the resident was oriented to self, but forgetful and confused with impaired decision making. The resident's assessment indicated the resident was independent with transfers with a four-wheeled walker and was, at times, resistive to cares and medication administration.

A complaint report indicated the facility did not have proper staffing or competent staff to care for the resident per the resident's care plan. The complaint report indicated because of staffing and/or lack of staff competency, the resident sustained falls and blisters on the resident's right buttocks.

Facility staffing plans were reviewed and personnel files were found to be in compliance with training requirements. Documentation reviewed supported that the facility provided medication administration audits on unlicensed staff who administer medication to the resident.

The resident's medical records indicated the resident received all services according to the resident's service plan, including medication management, escorts to the dining room and scheduled safety checks and the resident's family assisted with the resident's bathing care. The resident's medical records reviewed indicated the resident resided at the facility for approximately six months. During the resident's stay at the facility the resident fell four times. When falls with injury occurred, facility staff assessed and monitored the resident and sent the resident to the emergency room for evaluation. When the resident complained of pain following the falls, staff monitored and assessed the resident and had the resident evaluated when complaints of pain persisted. Services were increased when the resident required additional assistance with transfers. Documentation did not include evidence of any skin concerns found by staff during scheduled cares.

During an interview, the resident's family stated they had communicated concerns with the resident's plan of care and falls. The resident's family could not recall who called the resident's provider after the second fall, but the resident's provider was updated due to the chronic pain that seemed to be getting worse. The resident's family stated two blister-type open areas were found on the resident's right buttock after the resident discharged from the facility to their home. The resident's family stated the blister areas were treated with an antibiotic ointment and resolved within couple of weeks.

During an interview, facility administrative nursing stated the resident's services were increased approximately two days before the resident's discharge due to increased hip/leg pain. Facility administrative nursing staff stated there were no reports of skin concerns at the time of the resident's discharge.

During an interview, unlicensed staff, who cared for the resident the date before the resident's discharge stated she provided incontinent cares with another staff member and no skin issues were observed. The unlicensed staff stated she regularly checks for any redness when completing incontinent cares on residents. The unlicensed staff recalled the resident often refused cares and medications and was informed by the resident's family that if the resident refuses then: "no, means no." The unlicensed staff stated the resident was able to transfer independently and would often transfer to the bed and lay cross way on the bed. The unlicensed staff recalled a time when assisting the resident, the resident's family was present, everything was done according to the resident's care plan and the resident's family seemed to appreciate it.

During an interview, another unlicensed staff, staff recalled the resident was more independent with cares, but for approximately a week, the resident's condition changed resulting in the resident's services to include incontinent care with assist of two staff. The unlicensed staff stated she found no skin issues with the resident.

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, per family and resident's cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:

The facility provided competency training to care givers.
The facility completed incident reports and follow-up to falls.
The facility notified the resident's provider of incidents.
The facility completed staff audits of medication administration.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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
	31129	A. BUILDING: _____ B. WING _____	C 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN SENIOR LIVING	3715 COON RAPIDS BOULEVARD NW COON RAPIDS, MN 55433

(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 144A.43 to 144A.482/144G.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: #HL311296607C/#HL311293482M On June 25, 2025 through July 29, 2025, 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 92 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL311296607C/#HL311293482M, tag identification 2350.	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.	
02350 SS=D	144G.91 Subd. 7 Courteous treatment	02350		

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02350	Continued From page 1 Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure one of one resident (R1) was treated with courtesy and respect. Video footage from the resident's room camera displayed two unlicensed personnel (ULP) transfer R1 using the elastic of the resident's waist pants instead of a gait belt. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 resided in the licensee's memory care unit. R1's diagnoses included Alzheimer's Disease, chronic kidney disease and thrombophlebitis. R1's service agreement dated January 17, 2025, indicated R1 received services for dressing and grooming in the morning, laundry, medication administration, escorts to the dining room for two meals and safety checks five times per day. R1's Change in Condition Nursing Assessment dated May 13, 2025, signed by registered nurse/director of nursing (RN)-B, indicated R1 was alert and oriented to self with forgetfulness,	02350		

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02350	Continued From page 2 confusion and had impaired decision making. R1's nursing assessment indicated R1 received staff assistance with medication administration and was independent with transfers and ambulation with an assistive device. R1's nursing assessment indicated R1 was resistive to cares and medication administration. R1's progress notes dated May 13, 2025 at 1:18 p.m. by licensed practical nurse (LPN)-H indicated R1 was unable to bear weight due to increased pain in left groin area. R1's service delivery records dated May 15, 2025 at 12:45 p.m., indicated R1 started services for a second person assist. A video provided by R1's family member (FM)-G on July 8, 2025, at 3:37 p.m., indicated footage captured on R1's room camera dated May 15, 2025 at 4:28 p.m. The footage indicated two ULPs who attempted to transfer R1. One of the ULPs stood on right side of R1 and the other ULP stood on the left side of the resident. Both used an underhand grasp, under R1's armpits then used their other hand to grab R1's elastic waistband of her pants to lift R1 up off of the bed. R1 was stating: "no" during the transfer when the two ULPs placed R1 back on her bed. In the video footage, it could be observed that R1's pants were pulled up R1's buttocks during the transfer. According to this same video, both ULP's used the elastic waistband of R1's pants to scoot R1 up towards the head of her bed before being laid down. During an interview dated July 8, 2025, at 9;59 a.m., FM-G recalled R1's services for transfers changing on approximately May 11, 2025, to indicate the need for two persons to transfer R1	02350		

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02350	Continued From page 3 three times per day. FM-G stated the services were changed due to R1's increased pain in her lower legs. During an interview dated July 9, 2025, at 3:39 p.m., unlicensed personnel, (ULP)-R, stated when assisting with a transfer on May 16, 2025, R1's care plan indicated R1 was a two-person transfer but stated R1 could also transfer herself. ULP-R stated R1 could be noncompliant. During an interview dated July 10, 2025, at 9:03 a.m., RN-B stated a weekly note was distributed to all nursing staff to inform that R1 started services for a two-person lift shortly before R1's discharge on May 17, 2025. RN-B stated the two-person transfer was added to R1's service plan, but the service plan did not get signed before R1 was discharged. During an interview dated July 29, 2025 at 1:32 p.m., licensed assisted living director, (LALD)-A and RN-B stated all unlicensed staff are issued a gait belt on orientation and it is considered a part of their uniform. RN-B stated the licensee did not have a Gait Belt Policy, but used the Transfers and Ambulation Competency to train staff. RN-B stated extra gait belts are stored in a kit on each floor. RN-B stated all transfers that require an assist of one staff would warrant the use of a gait belt. RN-B stated if a resident required an assist of two for transfers a gait belt would be required. RN-B stated if a resident fell, it is protocol to have two-staff and a gait belt or mechanical lift to lift the resident off of the floor. RN-B stated, if a resident needed a staff assistance and a gait belt for transfers, it would be documented in the resident's service plan. RN-B stated that the use of a resident's pant's for lifting or transfers does not exclude the required use of a gait belt.	02350		

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02350	Continued From page 4 The licensee's Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, indicted "Residents have the right to be treated with courtesy and respect". The licensee's provided Transfers and Ambulation Competencies dated June 2021, indicated (8) place the gait belt around the resident's waist prior to transferring a resident. No further information was provided. Time Period for Correction: Seven (7) Days.	02350		