*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL311298802M
**Compliance #:** HL311292000C

**Date Concluded:** March 3, 2026

**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 R.N.
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 staff failed to follow the resident's plan of care which resulted in multiple falls with injury.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell multiple times and sustained injury, there was not a preponderance of evidence to support that the falls were a result of staff's failure to provide necessary care or services.

The investigator conducted interviews with facility staff members, including administrative nursing staff. 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 staff interactions and care provided to the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, history of falls and multiple fractures. The resident's service plan included assistance with dressing, grooming, bathing, toileting, escorting meals, medication management and safety checks. The resident's assessment indicated the resident was confused with impaired decision making. The resident received staff assistance with ambulating to the toilet, staff escort with a wheelchair to all three meals and safety checks every two hours throughout the night. The assessment indicated the resident transferred and ambulated independently with a walker while in her room.

The resident's medical record indicated the resident's physical ability declined over the last six months of her stay at the facility and the resident required more assistance with mobility and transfers and had an increase in falls. Following an illness that resulted in hospitalization, the resident was transferred to the memory care unit.

Review of the resident's record indicated the resident remained independent with transfers and ambulation to the bathroom. The resident sustained several unwitnessed falls as a result of self-ambulation attempts. When staff became aware of the falls, they assessed the resident and implemented interventions related to the falls. Documentation indicated facility staff included family in fall review and interventions. When staff suspected significant injury, the resident was transferred to the hospital for further evaluation.

The resident's medical records included fall reports, assessments, treatments provided and post-fall monitoring. The facility initiated several post-fall interventions to prevent future falls, such as requests for occupational and physical therapy, reminders to use the call pendant, assistive devices, an increase in staff assistance, grab bars throughout the room, and encouragement to wear non-slip footwear. Additionally, the resident's medical records included communication with the resident's family to change toileting service times to prevent future falls.

Following a fall that resulted in pelvic fracture, hospice services were initiated. The resident's hospice medical records indicated that the resident received additional care services through a hospice agency and post-fall intervention equipment that included a new hospital bed that adjusted positions, a table to keep next to the bed for personal items to be within reach and fall mats.

The resident's family members assisted in fall interventions and provided non-slip bedding, replaced the resident's recliner, purchased a new walker and provided support for the resident to start hospice services.

During an interview, the administrative nurse stated the resident admitted from the facility's assisted living to the facility's memory care after a decline in physical and cognitive abilities. The administrative nurse stated the resident's services in the memory care included staff assistance with dressing, grooming, oral care, bathing, escorts to and from meals with a wheelchair, safety

checks on the night shift and scheduled toileting that was adjusted throughout the resident's stay to prevent falls. The administrative nurse stated the resident was independent with a walker between scheduled service times.

During an interview, the resident stated she was impressed with her room at the facility, enjoyed the facility activities but felt the wait for assistance to the bathroom was at times too long. The resident reported that she felt safe residing at the facility.

During an interview, the resident's family stated that as the resident's condition declined, the resident sustained multiple falls with injury. The family stated they worked with the facility and were involved in the initiation of some post-fall interventions. The resident's family stated they communicated with facility staff when the resident needed assistance to go to the bathroom as the resident gradually declined in the ability to use her call pendent. The resident's family members stated they had expressed some concerns to facility staff, but felt care was provided appropriately and described most staff as "very good".

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**: Yes
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:**
The facility documented, assessed, implemented interventions and evaluated each fall.

**Action taken by the Minnesota Department of Health:**
No further action 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 |
|---|---|---|---|
| | 31129 | A. BUILDING: _____ B. WING _____ | C 02/03/2026 |

| 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<br><br>On February 3, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL311292000C/#HL311298802M. No correction orders are issued. | 0 000 | | |