Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL311293088M
Compliance #: HL311295085C

Date Concluded: March 7, 2023

Name, Address, and County of Licensee Investigated:
Autumn Glenn Senior Living
3715 Coon Rapids Boulevard Northwest
Coon Rapids, MN 55433
Anoka County

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

Evaluator's Name:
Katie Germann, RN, Special Investigator

Finding: Substantiated, individual responsibility

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 perpetrator (AP), a facility staff, financially exploited two residents (R1 and R2) by drug diversion when the residents' Tramadol and Hydrocodone tablets (narcotic pain medications) were taken for his own personal use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP was witnessed on camera taking R2's Tramadol from the kitchen drawer of R1 and R2's apartment.

The investigator conducted interviews with facility administrative staff and the residents. The investigator contacted law enforcement and the residents' family. The investigation included review of facility policies and procedures, facility investigation, resident rental agreement, and police report.

The residents resided at an assisted living facility but lived independently. R1 and R2 lived together independently and did not receive any care services from the facility. The residents managed their own medication.

Review of facility incident reports indicated R1 and R2 reported a history of missing narcotic medications. They reported three incidents where they found missing hydrocodone in large quantities. The first three instances had missing amounts of 80 pills, 90 pills, and 48 pills. After the first three instances, the residents installed a camera in their apartment. The final incident report detailed R1 was waiting in the parking garage for R2 to pick her up with the car to go to an appointment. The AP came off the elevator in the parking garage, asked R1 if they were leaving, and the AP turned around and went back into the facility. Before R1 and R2 left the parking garage, their phone was alerted through the camera application someone was in their apartment. The facility was notified by law enforcement the AP was observed on camera in R1 and R2's apartment looking through their belongings and taking pills from a pill bottle. The police showed the facility the recorded video footage and the facility staff identified the AP as a facility staff member.

The police report indicated R2 had gone to the pharmacy to pick up R1's medications. R2 placed the new bottle of medication with 180 pills of hydrocodone on the kitchen counter and R1 and R2 left the apartment and went to dinner. When they returned home approximately one hour later, 80 hydrocodone were missing. In another instance, R1 and R2 had gone to a meeting in the building. Prior to leaving the apartment, R1 and R2 hid R1's hydrocodone in the bedroom nightstand. When they came back from the meeting, 90 hydrocodone pills were missing. After that instance, R1 began to hide her medication in the closet behind other items. The third instance happened one evening after R1 and R2 returned from dinner and 48 of the hydrocodone pills that were hidden in the closet were missing. After that instance, R1 and R2 had cameras installed in the apartment. R1 placed four hydrocodone pills in plain view on her bedroom nightstand. Police review of the camera footage indicated the AP entered R1 and R2's apartment and announced himself. The AP immediately walked into the master bedroom and out of camera view, but audio is heard of drawers and doors being opened and closed. The AP can then be seen entering the living room area and proceeds to move cushions on the couch and look through drawers on the television stand. The AP then walks into the spare bedroom and opens the drawer next to the nightstand. The AP searches the kitchen area, then goes into the bathroom, turns on the light and searches the drawers and cabinets. The AP returns to the kitchen and searches drawers. The AP found a bottle in one of the kitchen drawers, looks at the label, opens the bottle and pours the pills into his hand, places the bottle back into the drawer, and puts the pills into his front left pants pocket. The AP then goes back into the master bedroom and then leaves the apartment. R1 reported to the police the pills in the kitchen drawer were R2's tramadol (a narcotic pain medication). R1 stated only 4 tramadol pills remained in the container after the AP was observed taking them, and there should be more left in the container. R1 reported the four hydrocodone pills she had set out on her nightstand were missing as well. The report indicated R1 stated she was upset and nervous because she couldn't figure out why she didn't have enough pills every month. R1 stated she got shingles

during this time and did not have any medication, so the resident began to split the pills in half to try to get by.

In an interview, R1 stated she was consistently missing her narcotic pain medication and suffered due to increased pain. R1 stated she began to ration her medications by cutting the pain pills in half. R1 stated she began to suspect the AP was taking both her and R2's narcotic pain medication after a resident council meeting where the AP was at but left shortly after R1 and R2 arrived at the meeting. After the meeting, R1's recently filled bottle of hydrocodone was missing "a lot of pills." R1 was unable to recall the specific number of pills that were missing. R1 and R2 told their family members about the missing narcotic medications and their family installed a camera in the apartment.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means: …
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, the AP did not respond to request for interview.

Action taken by facility:
The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Coon Rapids City Attorney
Coon Rapids Police Department

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 01/31/2023

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 LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 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: #HL311295085C/#HL311293088M On January 31, 2023, 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 82 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL311295085C/#HL311293088M, tag identification 2360.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure two of two residents, R1 and R2, were free from maltreatment. R1 and R2 were financially exploited. Findings include: On January 31, 2023, the Minnesota Department of Health (MDH) issued a determination that financial exploitation occurred, and that an individual staff person was responsible for the maltreatment, in connection with the incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	