Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL311299762M
Compliance #: HL311299321C

Date Concluded: May 14, 2025

Name, Address, and County of Licensee Investigated:
Autumn Glen Senior Living
3715 Coon Rapids boulevard 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, when, after five falls, the resident fell a sixth time, sustained a subdural hematoma, (brain bleed) and later, died at the hospital.

Investigative Findings and Conclusion:
Neglect was not substantiated. Although the resident sustained multiple falls, following each fall the resident was assessed and interventions were implemented. When the resident fell and sustained injury, the resident was sent to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including unlicensed staff. The investigator also contacted the resident's hospice case manager. The investigation included review of the resident record(s), death record, hospital records, facility internal investigations, facility incident reports, personnel files, staff schedules, and related facility policy and procedures Also, the investigator observed the facility environment, cares being completed and staff interaction with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included cerebral vascular disease and vascular dementia. The resident's service plan included assistance with dressing, hygiene, bathing, toileting reminders for ambulation with a wheeled walker, medication management, meals, safety checks, laundry and housekeeping. The resident's behavioral assessment indicated the resident had mild agitation, anxiety and depression.

The resident's medical records indicated four months prior to the multiple falls, the resident had a decline with his ambulation. The resident attended physical therapy and instead of being and it was recommended the resident use a four-wheeled walker for ambulation due to weakness.

The resident's facility medical records indicated two months prior to the multiple falls the resident was placed on hospice services due to behavioral and physical decline associated with dementia.

The resident's medical record further indicated the resident fell six times during a five-day period. During this time, the resident was on hospice services and being treated for a UTI. Prior to the resident's first fall, the resident's antipsychotropic medications (medication to assist with calming agitation) were increased due to the resident having an increase in agitation and noncompliance to care.

Documentation indicated that staff reported all six falls to nursing staff, the resident's family, resident's provider and hospice personnel. Facility nursing staff, as well as hospice nursing staff, assessed the resident and interventions such as antibiotics, medication review, furniture height, and ordered medical equipment including a lower bed, new wheelchair, and fall mat. Documentation indicated the resident did not sustain injury with the first five falls.

According to the resident's facility medical records, the sixth fall was witnessed and occurred in the facility lounge area. After falling, the resident was laying on his right side with blood was coming out of his nose. Staff also observed three skin tears on his right arm and a lump on the resident's right temple. Staff kept the resident on his right side to prevent aspiration and applied pressure to the nose in attempts to stop the bleeding. While the resident was being assessed he was observed going in and out of consciousness. While conscious, the resident was physically combative and hitting out at staff. 911 was called and the resident was transported to the hospital.

Two days after the resident was transported to the hospital, the resident was diagnosed with a subdural hematoma and discharged to a skilled nursing facility.

During an interview, the resident's family member stated the resident admitted to the facility due to an increase in elopements and physical aggression at home. The family member stated when the resident was admitted to the facility he ambulated independently, but as the

dementia progressed he needed a walker and more reminders due to forgetfulness. While at the facility, the family member stated the resident was noncompliant with cares and could become physically aggressive. The family recalled being concerned regarding the resident's behavior medications during the time of the falls but was informed by facility nursing staff that the medications were needed for the resident's increased behaviors.

During an interview, a facility nurse recalled the resident declined due to his dementia and with the decline, the resident became increasingly physically aggressive. The facility nurse also recalled the resident needed more assistance with care due to the aggressive behavior and non-compliance. The facility nurse recalled the resident's family member expressing concern over the resident appearing sedated and the facility nurse stated after hearing this, she assessed the resident while he was in his chair, and he did not appear sedated and was observed to be at baseline.

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 Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility assessed the resident following each fall, implemented interventions and transported the resident to the hospital when there was a change in condition.

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 03/31/2025

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 On March 31, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL311299321C/#HL311299762M. No correction orders are issued.	0 000		