Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL238581440M
Compliance #: HL238582220C

Date Concluded: April 11, 2025

Name, Address, and County of Licensee Investigated:

Autumn Grace II
110 Raven Court
Mankato, MN 56001
Blue Earth County

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

Evaluator's Name: Julie Serbus, 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 it did not provide adequate repositioning resulting in bedsores.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. No concerns related skin issues or open wounds were identified.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the guardian and resident's friend. The investigation included review of the resident record(s), facility progress notes, assessments, service plan, and related facility policy and procedures. Also, the investigator observed the resident's mobility and staff interaction with the resident.

The resident resided in an assisted living memory care building. The resident's diagnoses included high blood pressure and weakness. The resident's service plan included the resident was independent with transfers and ambulation.

The resident's assessment indicated the resident resided in an assisted living facility, was oriented to person, place, time and situation, and was not at risk for elopement and did not wander. The resident often refused services, and assessment indicated the resident had a mental illness.

A concern arose regarding the resident's skin and having bedsores due to lack of mobility. This concern also indicated the resident had difficulty ambulating related to resident not receiving physical therapy to regain strength and lack of exercise program and activities.

Review of the resident's skin assessments completed by the facility nurse indicated skin assessments had been completed with no skin concerns identified.

Upon admission, the resident's progress notes indicated no skin issues were identified. The progress notes also indicated the resident received physical therapy for her weakness and for strengthening. The resident has since been released from therapy and was independent with walking and transfers.

During an interview, a nurse stated the resident, on one occasion, had a small skin rash that was cleared up the next day just by applying lotion to the area. The nurse stated the resident declined going to activities but interest in exercise however did not opt to attend group exercises. The nurse stated the activities department had attempted one-to-one exercise, but the resident participated only briefly.

During an interview, an unlicensed caregiver stated the resident wants to be independent and remains in her room most of the time. Unlicensed caregiver stated the resident can ambulate independently with a walker.

During an interview, the guardian stated she is not aware of any skin concerns. Guardian stated the resident has been released from physical therapy and is encouraged to continue to walk and use the walker for distances. The guardian stated transportation is arranged per the resident's requests but once transportation or an outing such as church or senior day services, but the resident generally declines when the event comes about.

During an interview, a manager stated the resident will only talk to certain staff members. The manager stated the resident is allowed to leave the building on her own but requires staff to use a code to allow exit and entry to the building. The manager stated an activities calendar is posted in the facility.

The resident declined an interview.

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, resident declined
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: The facility is working with State Evaluations on compliance-related correction orders separately from this investigation.

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
	23858	A. BUILDING: _____ B. WING _____	C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GRACE II	110 RAVEN COURT MANKATO, MN 56001

(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 26, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL238582220C/#HL238581440M. No correction orders are issued.	0 000		