Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL391271541M
Compliance #: HL391276220C

Date Concluded: May 11, 2026

Name, Address, and County of Licensee Investigated:

Elysian Senior Homes
108 County 9 Blvd
Goodhue, MN 55027
Goodhue County

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

Evaluator's Name: Lena Gangestad
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 he was observed unresponsive during supper and subsequently passed away.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident unfortunately passed away due to an unforeseen incident, and staff had been following the care plan in providing care before and after the incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia and dysphagia (difficulty swallowing). The resident's progress notes

indicated the caregivers provided assistance with feeding. The resident's face sheet indicated the resident's code status was Do Not Resuscitate (DNR).

A concern arose when the resident was found unresponsive during supper and died.

The progress notes indicated the unlicensed caregivers contacted the on-call nurse because the resident had gone unresponsive during supper. The same notes indicated caregivers laid him down and obtained vital signs which indicated low blood pressure and called 911 immediately. When emergency medical services arrived the resident was pronounced deceased.

During an interview, an unlicensed caregiver stated the resident would eat very little and often refused food when offered. She said he would spit out food or refuse to eat entirely. She stated he was on a pureed diet and required feeding assistance. She said she was present in the dining room when he passed away. She explained the resident often shouted randomly, and when he suddenly became quiet, staff checked on him. She stated staff attempted to feed him as usual that day, but he spit out all food offered. Once staff found him unresponsive, she was unable to reach the nurse and called 911.

During an interview, a family member stated the resident was not in good health when he passed away. She said staff had done the best they could to care for him. She further stated he did not appear to be hungry, was eating very little, and required staff assistance with feeding. She said he had resided in the facility for less than two months and expressed no concerns regarding his care.

During an interview, the nurse stated the resident had been admitted to the facility from home because he was losing weight due to poor oral intake. She described him as very fragile. She stated his diet had been changed multiple times due to his condition and was eventually modified from regular to pureed consistency. She said staff were required to feed him three times daily.

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. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The staff member called 911.

Action taken by the Minnesota Department of Health: No further action taken 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
	39127	A. BUILDING: _____ B. WING _____	C 04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODHUE LIVING	108 COUNTY 9 BOULEVARD GOODHUE, MN 55027

(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 April 14, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL391271541M/HL391276220C. No correction orders are issued.	0 000		