



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 28, 2025

Licensee
Autumn Grace I
118 Raven Court
Mankato, MN 56001

RE: Project Number(s) SL30302016

Dear Licensee:

On July 16, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 24, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Benjamin J. Zwart'.

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 5, 2025

Licensee
Autumn Grace I
118 Raven Court
Mankato, MN 56001

RE: Project Number(s) SL30302016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2025
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NAME OF PROVIDER OR SUPPLIER AUTUMN GRACE I	STREET ADDRESS, CITY, STATE, ZIP CODE 118 RAVEN COURT MANKATO, MN 56001
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(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	<p>Initial Comments</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL30302016-0</p> <p>On April 21, 2025, through April 24, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 14 residents; 14 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 775	<p>Continued From page 1</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>During facility tour on April 24, 2025, from 12:24 p.m. through 12:54 p.m., with director of maintenance (DM)-I, the surveyor observed a curtain had been installed in resident room four to divide the room into two separate resident areas. The curtain blocked and limited the coverage of the fire sprinkler head in the room. DM-I stated the curtain was installed a few weeks ago when a second resident moved into room four. There was a similar curtain installed in resident room six.</p> <p>The fire sprinkler system sprinkler head coverage is required to be maintained as designed and installed at the time of original construction in accordance with State Fire Code in Minnesota Rules Chapter 7511, National Fire Protection Association (NFPA), and the local fire and building code official.</p>	0 775		

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0 775	Continued From page 2 DM-I verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	0 810		

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0 810	<p>Continued From page 3</p> <p>not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required training. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On April 24, 2025, at 2:58 p.m., director of maintenance (DM)-I provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN</p> <p>The licensees FSEP titled, Fire Alarm Policy, undated, lacked the following required content:</p> <p>The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. The evacuation map only</p>	0 810		

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0 810	<p>Continued From page 4</p> <p>included the resident room portion of the building. It did not include the area of the building known as Natural Surrounding in the FSEP. DM-I provided a copy of the floor plan for the entire building and stated they would add evacuation routes and include it in the FSEP.</p> <p>The FSEP did not include employee actions to take in the event of fire or similar emergency at this licensed facility. The employee actions in the FSEP were for Autumn Grace II, a different building on the same site. DM-I located the correct FSEP for this facility and stated they would update the employee actions and include them in the FSEP.</p> <p>The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.</p> <p>TRAINING</p> <p>Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. DM-I stated there was no documentation available for employee training.</p> <p>Record review indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. DM-I stated there was no documentation available for resident training.</p>	0 810		

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0 810	Continued From page 5 During an interview on April 24, 2025, at 1:32 p.m., DM-I stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services	01500		

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01500	<p>Continued From page 6</p> <p>and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (licensed practical nurse (LPN)-D).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and</p>	01500		

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01500	<p>Continued From page 7</p> <p>was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>LPN-D was hired on August 23, 2022, to provide direct care services under the licensee's assisted living with dementia care license.</p> <p>LPN-D's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.</p> <p>On April 22, 2025, at 2:56 p.m., licensed assisted living director (LALD)-A reviewed LPN-D's employee record and stated being unable to find evidence the above annual training had been completed as required.</p> <p>The licensee's undated, Required Annual Training Policy indicated: All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.</p> <p>No further information was provided.</p>	01500		

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01500	Continued From page 8	01500		
01620 SS=E	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a follow-up assessment within 14 days of admission for one of one resident (R1), and failed to complete a comprehensive</p>	01620		

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01620	<p>Continued From page 9</p> <p>reassessment not to exceed 90 calendar days from the last assessment for one of two residents (R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1 R1 was admitted on December 26, 2024, with diagnoses including type II diabetes mellitus, multiple myeloma (a cancer that forms in plasma cells) in remission, hypomagnesemia (low magnesium), hyperlipidemia (high cholesterol), restless leg syndrome, and dementia.</p> <p>R1's Service Plan effective December 26, 2024, 2023, indicated R1 received services including medication administration, blood glucose monitoring, bathing, grooming, dressing, toileting and incontinence assistance, transfers and ambulation, behavior monitoring, housekeeping, and laundry.</p> <p>R1's admission assessment was dated December 26, 2024. R1's 14-day assessment was completed January 13, 2025; 18 days after admission (4 days late).</p> <p>R2 R2's diagnoses included chronic kidney disease,</p>	01620		

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01620	<p>Continued From page 10</p> <p>type II diabetes mellitus, hemiplegia (severe or complete loss of movement function on one side) and hemiparesis (mild to moderate weakness on one side) following cerebral infarction (stroke) affecting right dominant side.</p> <p>R2's Service Plan effective January 18, 2024, indicated R2 received services including medication administration, blood glucose monitoring, assistance with bathing, grooming, dressing, toileting and incontinence assistance, transfers and ambulation, behavior monitoring, housekeeping, and laundry.</p> <p>R2's last three assessments were requested. Assessments dated July 26, 2024, October 30, 2024, and January 28, 2025, were provided. 96 days had passed between the July and October assessments, thus exceeding 90 calendar days.</p> <p>On April 22, 2025, at 2:56 p.m., clinical nurse supervisor (CNS)-B reviewed R1 and R2's assessments. CNS-B stated R1's 14-day assessment had been completed late as well as R2's October 2024, assessment.</p> <p>The licensee's Initial and On-Going Nursing Assessment of Residents policy revised February 2, 2024, indicated:</p> <ol style="list-style-type: none"> 1. A RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: <ol style="list-style-type: none"> a. Pre-Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition 	01620		

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(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
01620	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
02320 SS=D	<p>144G.91 Subd. 4 (b) Appropriate care and services</p> <p>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of two residents (R2) observed during medication administration.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2's diagnoses included chronic kidney disease, type II diabetes mellitus, hemiplegia (severe or complete loss of movement function on one side) and hemiparesis (mild to moderate weakness on</p>	02320		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2025
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NAME OF PROVIDER OR SUPPLIER AUTUMN GRACE I	STREET ADDRESS, CITY, STATE, ZIP CODE 118 RAVEN COURT MANKATO, MN 56001
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(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
02320	<p>Continued From page 12</p> <p>one side) following cerebral infarction (stroke) affecting right dominant side.</p> <p>R2's Service Plan effective January 18, 2024, indicated R2 received services including medication administration.</p> <p>R2's provider orders dated March 27, 2025, included the following: ciclopirox olamine 0.77% external cream (used to treat fungal skin infections). Wash and thoroughly dry breast/abdominal/groin folds and then apply and rub in a thin film to these affected areas twice daily.</p> <p>R2's medication administration record (MAR) dated April 2025, included the above order scheduled daily at 8:00 a.m., and 8:00 p.m.</p> <p>On April 22, 2025, at 10:01 a.m., the surveyor observed unlicensed personnel (ULP)-C administering medications to R2 including the ciclopirox olamine cream. ULP-C donned gloves and applied the cream under R2's breast, groin, and abdominal folds. ULP-C did not first wash and thoroughly dry R2's breast, groin, and abdominal folds prior to applying the cream. When interviewed immediately following the observation, the surveyor asked ULP-C if she ever offered/educated R2 on the importance of washing and drying the folds prior to the cream application. ULP-C indicated it depended on R2's mood.</p> <p>On April 23, 2025, at 8:33 a.m., clinical nurse supervisor (CNS)-B stated she would expect staff to offer to cleanse and dry R2's breast, groin, and abdominal folds prior to the ciclopirox olamine cream application per the physician order, although it is the resident's right to refuse.</p>	02320		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2025
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NAME OF PROVIDER OR SUPPLIER AUTUMN GRACE I	STREET ADDRESS, CITY, STATE, ZIP CODE 118 RAVEN COURT MANKATO, MN 56001
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02320	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		



**DEPARTMENT
OF HEALTH**

Type: Full
Date: 04/21/25
Time: 11:00:00
Report: 1033251148

Food and Beverage Establishment Inspection Report

Page 1

Location:

Autumn Grace
118 Raven Court
Mankato, MN56001
Blue Earth County, 07

Establishment Info:

ID #: 0017651
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

MS-AC Mankato AG Senior Living

Phone #: 5073880640
ID #: 46792

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

FACILITY HAS ALL MEALS DELIVERED AND PASSED OUT TO ALL THE RESIDENTS. ALL DIRTY DISHES ARE TAKEN AND CLEANED AT ANOTHER FACILITY. THERE IS NO FOOD STORED AT THIS LOCATION.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1033251148 of 04/21/25.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed:  _____

Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us