Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356362225M
Compliance #: HL356363849C

Date Concluded: July 18, 2025

Name, Address, and County of Licensee Investigated:
Benedictine Asher Haus
717 1st Street North
Cold Spring, MN 55320
Stearns County

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

Evaluator's Name: Danyell Eccleston, 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 Resident #1 and Resident #2 when the facility failed to provide appropriate supervision. Resident #1 and Resident #2 were cognitively impaired and unable to make personal decisions without family oversight. Resident #1 and Resident #2 had a verbally abusive and sexual relationship.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although there is information that Resident #1 and Resident #2 were found naked in the same room on one occasion, it is not known if a sexual act occurred. Information indicated Resident #2 told Resident #1 what to do and where to sit during meals, however, the facility put interventions in place to give Resident #1 other options. Resident #1 and Resident #2 sought out each other's company, desired interaction with each other and were able to have appropriate interaction.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed Resident #1 and Resident #2 interacting with each other and staff members providing care to residents.

During observation, Resident #1 and Resident #2 walked the hallway together and in a separate observation were standing in Resident #2's apartment looking at photos. No inappropriate physical contact was seen and no inappropriate conversation was heard.

Resident #1 resided in an assisted living memory care unit. The resident's diagnosis included Alzheimer's disease. Resident #1's service plan included assistance with disorientation, redirection, and decision making. Resident #1's assessment indicated it was important for Resident #1 to be able to visit with other residents and staff and needed redirection with a calm, gentle, and validating approach.

Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included dementia. Resident #2's service plan included assistance with safety checks and behavioral intervention to redirect and calm. Resident #2's assessment indicated the resident had moderate impairment and memory loss, was hard of hearing, and could be verbally aggressive and sexually inappropriate to female staff at times.

Review of Resident #1's progress notes from the past three months indicated Resident #1 and Resident #2 had meals together and would walk in the halls together. Progress notes indicated Resident #1 spent time in Resident #2's apartment and the residents napped in separate recliners. Progress notes also indicated staff members encouraged Resident #1 to interact with other residents and attend activities.

Review of Resident #2's progress notes from the past three months included a time when Resident #2 became upset and started to yell when there was not room for Resident #2 at a table where Resident #1 was sitting with other residents. Staff members redirected Resident #2 to sit at an empty space at another table and redirected Resident #2 and allowed voicing of frustration.

During conversation with an outside care giver, an instance when Resident #1 and Resident #2 were found unclothed in Resident #1's apartment was mentioned. Time frame of instance and information regarding any sexual activity were unable to be given. The outside caregiver declined formal interview.

During interview, a leadership member stated concerns came forth regarding Resident #1's mental capacity and ability to have a safe relationship with Resident #2 as well as concerns that Resident #1 and Resident #2 should not be in either's apartment with the door shut. The leadership member stated both Resident #1 and Resident #2 seek each other out during the day

and often interact appropriately and hold hands. The facility staff made efforts to ensure doors are open when Resident #1 and Resident #2 are in an apartment and visually observe Resident #1 and Resident #2 when they were together to ensure safety.

During interview, a nurse stated she had not noted any concerning physical interaction between Resident #1 and Resident #2, but Resident #2 had a gruff voice in general and at times vocalized what he wants Resident #1 to do, however, staff redirected and assisted to ensure Resident #1 and Resident #2 participate in activities they each like.

During interview, an unlicensed staff member indicated staff encourage Resident #1 and Resident #2 to interact with other residents and participate in group activities. Staff implemented a meal seating chart to ensure Resident #1 also has meals with other residents she enjoys.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No further action taken at this time.

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
	35636	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE ASHER HAUS	717 1ST STREET NORTH COLD SPRING, MN 56320

(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 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: #HL356363849C/#HL356362225M , #HL356365370C/#HL356362962M On July 4, 2025, 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 27 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL356365370C/#HL356362962M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of three residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	Assisted Living Provider 144G. 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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.	