Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H52367402M
Compliance #: H52366383C

Date Concluded: March 23, 2026

Name, Address, and County of Licensee Investigated:
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811
St. Louis County

Facility Type: Nursing Home

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Substantiated, individual responsibility

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 alleged perpetrator (AP) sexually abused the resident when he entered the resident's room with his unzipped pants, exposing himself to the resident. He then grabbed the resident's hand and placed it on his genital area, resulting in direct skin-to-skin contact.

Investigative Findings and Conclusion: The Minnesota Department of Health determined sexual abuse was substantiated. The AP was responsible for the maltreatment. The narrative of both the AP and the resident are consistent indicating abuse occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the residents' records, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in a nursing home facility and was diagnosed with hemiplegia and aphasia. The care plan indicated the resident required assistance with bed mobility and management of urinary catheter. The care plan also indicated altered communication ability related to expressive aphasia; however, the resident did not exhibit cognitive impairment or dementia and had a Brief Interview for Mental Status (BIMS) score of 15.

A concern arose when the resident reported inappropriate actions by the AP during the night shift to the facility's management team.

Compliance survey notes indicated the resident was nonverbal and unable to move her right arm; however, she was able to respond to yes-or-no questions by nodding her head. The resident indicated the incident occurred during the provision of personal care at approximately 5:00 a.m. She spelled out "dick" to identify the body part involved and confirmed that her hand was physically moved by the AP. The resident became tearful during the interview. When asked whether the contact occurred over clothing, she responded "no." When asked whether the contact involved skin-to-skin contact, she responded "yes."

During an interview, the facility social worker stated the resident began crying when asked about the incident. When asked whether the AP touched her, the resident nodded "yes." When asked whether the incident occurred during care, the resident again nodded "yes." The social worker asked whether the contact was appropriate, and the resident indicated "no." When asked where the touching occurred, the resident spelled out "D-I-C-K" using a communication board. When asked whether staff physically moved her arm or hand, the resident spelled out "hand." When asked whether the staff member guided her hand to touch a specific body part, the resident nodded "yes." When asked whether the contact involved skin-to-skin contact, the resident nodded "yes." The resident repeatedly vocalized the word "hand." When asked whether the staff member used her hand to perform sexual acts, the resident nodded "yes." When asked whether penetration occurred, the resident responded "no."

During an interview, the manager stated the resident was able to mouth words and speak simple words. The manager stated the resident was alert and oriented. The manager asked the resident to identify the staff member involved, and the resident nodded "yes" when asked whether it was [the AP's name]. The manager stated the resident indicated the incident occurred at approximately 5:00 a.m. This time was corroborated by the night nurse, who reported walking past the resident's room at that time and confirmed the AP was present in the room.

During an interview, the AP stated he had worked at the facility for eight years. He stated that on the night of the incident, he used the bathroom prior to entering the resident's room and used a new wipe on himself for the first time. He reported experiencing irritation and a burning sensation. He stated he entered the resident's room to provide care and that his genital area continued to burn due to the wipe. He stated he turned away toward an empty bed and exposed himself to cool down. He stated that while this occurred, the resident attempted to

speak, and he moved closer to the edge of the bed to hear her due to her soft speech. He stated he did not believe the resident saw his exposed genital area. He stated he did not ask anyone for help with the resident's care because the other aide working that night was busy. He stated he left work a few minutes early and showered upon returning home due to discomfort. He denied that the resident touched his genital area but stated he had one hand on his genital area while the resident held his other hand.

In conclusion, the Minnesota Department of Health determined sexual abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Definitions: 609.341

Subd. 5.Intimate parts.
"Intimate parts" includes the primary genital area, groin, inner thigh, buttocks, or breast of a human being.

Subd. 11.Sexual contact.
(a) "Sexual contact," for the purposes of sections 609.343, subdivision 1, clauses (a) to (e), and subdivision 1a, clauses (a) to (f) and (i), and 609.345, subdivision 1, clauses (a) to (d) and (i), and

subdivision 1a, clauses (a) to (e), (h), and (i), includes any of the following acts committed without the complainant's consent, except in those cases where consent is not a defense, and committed with sexual or aggressive intent:
(i) the intentional touching by the actor of the complainant's intimate parts, or
(ii) the touching by the complainant of the actor's, the complainant's, or another's intimate parts effected by a person in a current or recent position of authority, or by coercion, or by inducement if the complainant is under 14 years of age or mentally impaired, or
(iii) the touching by another of the complainant's intimate parts effected by coercion or by a person in a current or recent position of authority, or
(iv) in any of the cases above, the touching of the clothing covering the immediate area of the intimate parts, or
(v) the intentional touching with seminal fluid or sperm by the actor of the complainant's body or the clothing covering the complainant's body.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: No. The resident did not wish to contact her family about this issue when she was alive.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility initiated an internal investigation and interviewed other residents to determine whether they had any concerns involving the AP. The AP was suspended pending investigation and subsequently resigned when asked to participate in an interview. Law enforcement was notified.

The resident was assessed, and a skin assessment was completed. Education was provided to all staff regarding the facility's Behavioral Health Care (BHC) Abuse Policy, reporting requirements, and the need for heightened awareness of and response to sexual abuse allegations. The resident's primary care provider was notified. The resident's care plan was updated to require care to be provided by two staff members and to identify preferred caregivers.

Action taken by the Minnesota Department of Health: MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

The purpose of this investigation was to determine individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
St. Louis County Attorney
Duluth City Attorney
Duluth Police Department

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center	**935 KENWOOD AVENUE , DULUTH, Minnesota, 55811**

(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) COMPLETION DATE
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H52367402M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #H52367402M, tag identification 21850. The facility has agreed to participate in the	20000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center	**935 KENWOOD AVENUE , DULUTH, Minnesota, 55811**

(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) COMPLETION DATE
20000	Continued from page 1 electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul .htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		