Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202862122M
Compliance #: HL202863668C

Date Concluded: July 2, 2025

Name, Address, and County of Licensee Investigated:
Benedict Homes
1340 Minnesota Boulevard
St. Cloud, MN, 56304
Sherburne County

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

Evaluator's Name: Angela Vatalaro, 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 staff failed to provide the resident supervision and as a result, the resident attempted suicide and sustained multiple self-inflicted wounds and was involved in a resident-to-resident altercation. In addition, the resident resided in memory care unit and did not have memory problems.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Prior to the self-harm incident, the resident did not voice to staff any suicidal thoughts, ideation, or have a history of self-inflicted wounds. The resident had hidden a razor blade in the sole of his shoe. The resident had no history of resident-to-resident altercations. During one altercation, staff immediately intervened and separated the residents without injury. The resident's admission to the memory care unit was appropriate and approved by his provider for his diagnoses of major neurocognitive disorder (deficit in cognitive functioning.)

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, law enforcement report, and related facility policy and procedures. Also, the investigator observed the resident and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included major neurocognitive disorder and major depressive disorder. The resident's service plan included assistance with bathing and medication administration. The resident's assessment indicated the resident was alert, oriented, independent with dressing, toileting, and walked with a cane.

The facility's internal investigation indicated one day, staff had found cuts on the resident's wrists and forearms of both arms. Licensed staff assessed the wounds and provided wound care. The resident admitted to self-infliction of the cuts with a razor blade and agreed to treatment for the wounds and his mental health. Nursing staff stayed with the resident until the resident left the facility for an evaluation at a hospital.

The law enforcement report indicated the facility contacted law enforcement, reported the incident, and spoke to law enforcement.

Hospital Records indicated the resident had a history of neurocognitive disorder, executive function deficit (disrupts ability to manage thoughts, emotions, and actions,) and major depressive disorder. The resident had stated the day prior to staff finding the wounds, he tried to kill himself by cutting his arms using a razor blade that he had purchased over a month ago while being "checked out" of the facility. The resident had superficial lacerations (cuts) throughout both upper extremities with deeper wounds to both his antecubital spaces (area between the arm and forearm) with one side having adipose (fat) tissue exposed. The deeper wounds were not able to be sutured closed as it had been over 24 hours since the injury. The resident stated in the last few weeks he had begun experiencing suicidal ideation and was having difficulty living in a locked unit and his lack of independence. The resident had no history of suicide attempts or self-harming behavior and no current suicidal ideation. The resident transferred to an inpatient mental health unit.

The resident's hospital discharge records indicated the resident reported long standing cognitive difficulties, particularly with his memory, and described notable memory loss. The resident discharged back to the facility five days later.

Prior to the incident, the resident's record indicated the resident had no history of suicidal ideation or other incidents of self-harm. After the incident, records indicated interventions were added including behavior monitoring for self-injurious behaviors, daily room checks, socialization tasks, exploration of companion services, and arranging for a psychiatry provider for the resident.

Two weeks after the hospital discharge, records indicated the resident had sworn at another resident about placement of the other resident's coffee cup and pushed the coffee cup towards the other resident. Staff were able to separate and redirect the resident. Later that same day, when checking the resident's room, staff found items including a scissor and the resident had expressed intent to harm himself. The facility arranged for an evaluation of the resident at a hospital.

Emergency room records indicated the resident stated the scissor and two razors found in his room at the facility today were the items he had hidden before his first hospitalization. The resident denied obtaining any new razors since his hospitalization, denied suicidal ideation, and a suicidal intent or plan. The following day, the resident discharged back to the facility. The resident also reported he did not like his current living situation and wanted to find a place where he could come and go as he wanted.

The resident's record indicated upon return from the emergency room, the resident said he had no intent to harm himself and was upset that another resident got into his space. Facility staff developed Interventions to keep the two residents separated to reduce agitation.

The resident's provider notes indicated during a follow-up visit for his hospitalization and recent emergency room (ER) visit, the resident stated the ER visit was a misunderstanding and regarding his depression symptoms stated he felt "much better" and denied any suicidal ideation. Provider notes indicated the resident had several memory/cognitive tests completed that determined the resident struggled with memory and executive functioning (problem solving, managing tasks and achieving goals.) The provider indicated the resident benefited from a supervised setting such as a memory care assisting living.

During an interview, an unlicensed personnel stated the incident of the resident self-inflicted arm wounds was a big shock to staff as the resident always reported to staff he was doing okay. The resident would be seen out of his room, at times participated in activities, and he would be out in the communal living room.

During an interview, another unlicensed personnel stated she provided medications to the resident the day the resident's self-inflicted arm wounds were noticed. The unlicensed personnel stated that morning, during medication administration, there was nothing different with the resident, he was the same that he was every day. The resident took his medications and said he may be down for breakfast which was normal for him. The unlicensed personnel stated she did not see his arm wounds when administering medications. The resident was lying in bed, was covered up, and had long sleeves on. Later that day, the resident was sitting in a living room. Another unlicensed personnel noticed the scratches on the resident's wrists. The unlicensed personnel stated the resident reported a dog had scratched him. Staff immediately reported the wounds to a nurse. The unlicensed personnel stated there were no prior occasions of the resident stating he wanted to hurt or harm himself.

During an interview, a nurse stated it was reported by staff that the resident had scratches on his wrist and hands caused by a dog. The nurse stated she assessed the resident and questioned the resident about what happened. The nurse stated the marks were not scratches or a bite from a dog; they were cuts. The nurse stated the resident had cuts up and down both his arms and in the creases of his arms. The nurse stated the resident admitted to cutting himself. The nurse stated the cuts were not actively bleeding and the wounds were cleansed and dressed. The nurse updated leadership, the provider, and coordinated a transfer of the resident to the hospital for an evaluation. The nurse stated prior to the incident, the resident had never showed self-injurious behaviors at the facility or made any comments of wanting to harm himself. Upon return from the hospital, services were added for the resident's safety. The nurse stated after the resident returned from the hospital, there was an occasion when the resident had a verbal outburst towards another resident regarding a coffee cup, which was abnormal behavior for the resident. Due to this behavior, the resident's room was searched again, and a scissor and razor blades were found. The nurse stated the facility again arranged for the resident to be evaluated at a hospital and he discharged back to the facility the next day. The nurse stated since that incident, no other items had been found in the resident's room, no further incidents of self-harm, and the resident had not voiced any further comments of wanting to harm himself. The nurse stated the facility was currently assisting the resident, according to the resident's wishes, in finding different placement to offer a change of scenery for the resident.

During an interview, another nurse stated the resident was in a locked memory care unit and had a diagnosis of major neurocognitive disorder. The nurse stated prior to the resident's initial admission he had cognitive issues and was admitted to memory care from a hospital. The nurse stated in addition, the resident had undergone cognitive testing while at the facility, and it was suggested by a provider that the resident reside in a memory care unit. The nurse stated the resident hid a razor blade in the sole of a shoe and staff could not determine how or when the resident obtained the razor blade. The nurse stated there was an incident a couple weeks after the resident's hospitalization when items that could be used to self-harm were found in the resident's room including a scissor and the resident was evaluated at a hospital and returned to the facility. The nurse stated the facility arranged for a mental health provider to visit the resident at the facility. The nurse stated staff routinely searched the resident's room for items that could cause self-harm. The facility was working with the resident's care team on alternate placement as the resident expressed a desire for a different place to live.

During an interview, leadership stated the resident had been content at the facility prior to the self-inflicted arm wounds incident. Leadership stated the resident had no prior reports of thoughts of self-harm or suicidal ideation. Leadership stated the facility did not have sharp scissors accessible, used rounded tip school scissors for activities, and the resident did not have access to razor blades. Leadership stated prior to the incident, the resident had staff supervision including the facility standard of two-hour safety checks. Leadership stated following the incident staff safety checks were increased.

During an interview, the resident's guardian stated the resident had no history of self-inflicted wounds or voiced suicidal ideation prior to the incident. The resident had hid scissors and sharp objects at the facility that he used to cut his arms. The resident's guardian stated prior to the incident, the resident reported he was happy at the facility and liked living there. After the incident, the resident said he was not happy living there. The resident's guardian stated she had no concerns with staff supervision of the resident. The facility, guardian, and a social worker were all working together in attempts to find the resident new placement.

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

Action taken by facility:
Once the self-inflicted wounds were seen, the facility provided the resident wound care and coordinated transfer to the hospital for evaluation. After the incident, the facility added services to the resident's plan of care to include daily socialization, increased the resident's safety checks, added interventions for isolation, depression, and self-injurious behaviors to include room checks for objects that could be used to self-harm. The facility added mental health provider rounding for the resident and coordinated twice weekly companion services. The facility provided education to staff for warning signs of depression and suicidal ideation. The facility also provided staff resource numbers to call for mental health emergencies.

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
	20286	A. BUILDING: _____ B. WING _____	C 06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICT HOMES	1340 MINNESOTA BOULEVARD SE SAINT CLOUD, MN 56304

(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 June 9, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL202863668C/#HL202862122M. No correction orders are issued.	0 000		