Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202917262M
Compliance #: HL202916942C

Date Concluded: March 24, 2026

Name, Address, and County of Licensee Investigated:
The Villa Benedictine
135 Pioneer Road, 134
Red Wing, MN 55066
Goodhue County

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

Evaluator's Name: Christine Bluhm, 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: The alleged perpetrator (AP) abused two residents (resident #1 and resident #2) when she recorded them with her cell phone and shared them on social media (Snap Chat).

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse and neglect were substantiated. The AP, an unlicensed caregiver, was responsible for the maltreatment.

Resident #1: The AP abused the resident by recording herself asking resident #1 inappropriate questions, not offering assistance, and then posting that video on social media (Snap Chat) treating the residents needs in a disparaging way.

Additionally, the AP neglected resident #1 during the same interaction by not providing assistance for the resident. As the video ends, the resident falls from her wheelchair to the floor.

Resident #2: The Minnesota Department of Health determined abuse was inconclusive. While there were reports the AP recorded and posted videos of resident #2, no video evidence was available for the investigation to review.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement reports, and related facility policy and procedures. Also, the investigator observed staff interactions with memory care residents and cell phone use on a recent visit to the facility.

Both residents resided in an assisted living memory care unit.

Resident 1's diagnoses included dementia, anxiety, visual impairment and a history of falls. The resident's service plan included assistance with all activities of daily living and medication management. The resident used a wheelchair for mobility and was a risk for falls.

Resident 2's diagnoses included Alzheimer's disease. The resident's service plan included assistance with all activities of daily living and medication management. The resident used assistive devices to aid mobility and was a risk for falls.

A concern arose when the AP had recorded and shared multiple videos of residents for non-work purposes.

A law enforcement report indicated the AP recorded multiple residents while working at the facility. Two videos were retrieved. Other videos were reported as viewed but were not able to be retrieved as evidence.

One video, which included audio, showed the resident #1 in her wheelchair while a caregiver, the AP, sitting observing her and asking her questions. The AP asks questions including "can you lay in bed for me" while intermittently giggling. The video showed the resident backing away from the bed while placing both hands on the arm rest of her wheelchair and leaning forward as if to initiate a transfer, however she did not rise from the chair. The AP says at one point to "not go on the floor" but does not offer nor provide physical assistance. While the video recording continued, not long afterwards, the resident falls out of the wheelchair and onto the floor. The video ends as this occurs.

During investigative interviews, multiple caregivers stated the AP either shared videos of residents or were told about the videos.

During an interview, an unlicensed caregiver stated the AP told her she recorded resident #1 while she was falling and the AP thought it was funny. The caregiver stated the resident did not seem to be her usual self when the AP was in the room during caregiving activities.

During an interview, a nurse stated she learned the AP had taken videos of residents, started an investigation, and discovered the videos of residents. The nurse stated the videos included the AP asking inappropriate questions to recording a resident sliding out of the wheelchair after mocking the resident. The nurse stated facility policy prohibits the recording of residents. The nurse stated the recording and allowing a resident to fall to the floor was very concerning.

The facility's policy on the use of personal electronic devices indicated staff may not take photos or recordings of residents unless they have both a business need to do so and signed permission and act in accordance with the strict requirements applicable to those activities.

During an interview, the AP stated she took the videos of residents so she could show a friend who was interested in working at the facility. The AP stated she thought the resident was re-adjusting herself in the wheelchair when she fell. The AP said she sent videos of residents to other co-workers and deleted the videos once she learned it was not okay to have them.
She said she did not remember cell phone use policy training at the facility although the AP's employment file indicated she signed off that received the facility's cell phone policy.

During interview, one family member stated the family had not seen the video but was told the resident was videoed while watching her fall. The family member stated the reason the resident was moved into memory care was to monitor more closely for falls.

Regarding resident #2, no video was recovered for this investigation.

In conclusion, the Minnesota Department of Health determined abuse and neglect were 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.

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, due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility: The facility interviewed all staff and residents who may have been affected. The facility vulnerable adult policy and cell phone use policy were reviewed with each staff member. The AP no longer worked at the facility.

Action taken by the Minnesota Department of Health: The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

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

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
Goodhue County Attorney
Red Wing City Attorney
Red Wing Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20291	A. BUILDING: _____ B. WING _____	C 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | RED WIN	135 PIONEER ROAD RED WING, MN 55066

(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 The Minnesota Department of Health investigated an allegation of maltreatment, complaint #HL202917262M / HL202916942C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued tag identification 2360.	0 000	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure of one of two residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		