Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306873102M
Compliance #: HL306875531C

Date Concluded: September 11, 2025

Name, Address, and County of Licensee Investigated:
Benedictine Senior Living Osseo
625 Central Avenue
Osseo, MN
Hennepin County

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

Evaluator's Name: Julie Serbus, 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 it failed to perform scheduled a safety check over night or in the morning.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident was found on the floor between his bed and the wall, the caregivers were familiar with his routine and had adapted his cares to that routine. The facility took appropriate action to address the resident's cares.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, tasks report, progress notes, service plan, evaluations, and related facility policy and procedures. The investigator visited the facility, and staff gave a tour of the resident's apartment and explained how it was set up and where resident was found between the bed and wall.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, anxiety, and other mental health conditions. The resident's assessment indicated the resident received medication administration with medications being adjusted by psychiatry provider related to concerns regarding sleep patterns. The resident was prone to wandering the unit plus confused to place and time. The resident required frequent/daily interventions regarding personal space of others and was independent with toileting and ambulation. The resident assessment indicated daily "I am okay checks" plus multiple safety checks daily.

One morning a caregiver went into the resident's room to check on the resident and found the resident not to be in his bed. The caregiver reported off to other staff members the resident could not be located, and a search began for the resident throughout the unit and facility. The nurse was contacted along with the police department. The resident was found in his room on the floor between his bed and the wall. Resident was assessed and transported to the emergency department for evaluation.

During an interview, multiple caregivers stated the resident wandered throughout the unit both day and night and was highly visible. Verbal report was given between shirts to share information about what occurred on the previous shift. Multiple caregivers stated the resident does not sleep well and generally allow him to rest and try they try not to disturb him overnight or in the morning in the beginning of the dayshift.

During an interview, a family member stated this was the first incident like this and his family member was sent for evaluation. Family member stated the resident was having increased confusion and is now in a higher level of care facility related to his dementia.

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: NA

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: NA

Action taken by facility: The facility sent to the resident to the hospital for evaluation. The resident did not return to the facility but was residing at a higher level of care facility.

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

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

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
	30687	A. BUILDING: _____ B. WING _____	C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE SENIOR LIVING	625 CENTRAL AVENUE OSSEO, MN 55369

(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: #HL306875531C/#HL306873102M On July 1, 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 48 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL306875531C/#HL306873102M, tag identification 0730.	0 000	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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record	0 730		

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0 730	Continued From page 1 Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and	0 730		

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0 730	Continued From page 2 any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on record review and interviews, the licensee failed to ensure the contents of a resident record included a service plan which was updated with information obtained in the resident evaluation regarding safety checks for one of one resident reviewed. R1 had been found on the floor between his bed and the wall. R1 had been there for an undetermined amount of time and required hospitalization. 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). The findings include: R1's face sheet indicated he lived in the secured memory care unit of the facility. R1's diagnoses include dementia, anxiety, and other mental health conditions. R1's nursing evaluation dated April 14, 2025, indicated the resident received. R1's evaluation indicated a daily housing check or "I am OK	0 730		

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0 730	Continued From page 3 check" included in the fee per regulation. The same evaluation indicated multiple additional daily safety checks which excluded the housing required checks. R1's service plan dated April 14, 2025, indicated R1 wanders in private areas requiring redirection with staff to check for unmet needs and provide redirection. However, no listed times scheduled for this task to direct staff on how often the checks were required or where to document when checks had been completed. Review of requested task history report for May 11, 2025, through May 14, 2025, indicated no documentation for a daily housing "I am okay checks" or additional checks throughout a 24-hour period. The facility could not supply documentation of staff being directed to provide safety checks. During an interview on July 1, at 11:53 a.m., registered nurse (RN)-C stated she was unaware of safety check tasks. RN-C stated overnight staff visually saw the resident at the beginning of the shift on May 13, 2025, at 11 p.m. RN-C stated prior to this event a sleep sheet was implemented related to R1 not sleeping. If R1 had a risk plan for checks then there would have been a place for staff to initial off checks and did not remember if this was care planned for R1. During a second interview on July 29, 2025, at 11:00 a.m., RN-C stated she located the sleep sheet for the resident which was in a binder and had not placed in R1's permanent closed chart. During an interview on July 10, 2025, at 12:15 p.m., RN-F stated staff are responsible for tasks that show up on the tablets or phones. RN-F stated the evaluation is the document that	0 730		

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0 730	Continued From page 4 populates the service plan which staff use to care for residents. RN-F stated scheduled times for tasks are listed on the evaluation which then populate the service plan. RN-F stated in memory care they had 24-hour report sheets along with sleep monitoring forms where overnight staff would document rounds. During an interview on July 15, 2025, at 10:30 a.m., unlicensed personal (ULP)-I stated resident did not have scheduled checks listed on the daily tasks in the computer. ULP-I stated tasks assigned to staff are listed on the service plan and that is where you would initial when the task has been completed. During an interview on July 16, 2025, at 2:41 p.m., registered nurse (RN)-H stated the facility considers evaluations the same as a nurse assessment and that is what drives the plan of care. Every resident is checked on one time per day and that could be any time such as during a meal, medication pass, or another service. RN-H stated this included "I am okay checks" which are not documented. RN-H stated if R1 required every two-hour check nursing would list this on the evaluation and populate care plan. Pops up on point of care in the resident matrix. She confirmed on evaluation he did not have safety checks listed. Not aware of any policy or training that states staff at the beginning of their shift need to do a check During an interview on July 17, 2025, at 11:17 a.m., ULP-D stated when staff came on shift the evening of May 13, 2025, she had received report from previous shift and then made rounds to visibly check on each resident. That is just the right thing to do and her personal preference. ULP-D stated we do not document the checks as	0 730		

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0 730	Continued From page 5 they are not on the tasks. ULP-D stated on the overnight shift there is a sleep log form which is paper and not electronic where we have chart resident's sleep patterns. Charted on sleep chart slept all night, reported to morning shift. During an interview on July 23, 2025, at 10:00 a.m., management (Mgt)-B stated tasks for a resident were based off service plan generated in Matrix where they also complete electronic charting. Mgt-B stated if not documented and not listed in the care plan then it was not done. The care plan would be where staff were assigned tasks for each individual resident. A Service Plan Policy, revised March 3, 2022, indicated a service plan is developed by a registered nurse based upon the uniform assessment. Service plans are communicated to assist associates in understanding the resident's person-centered daily needs and tasks. A Documentation policy, No# POL_MNAL 03.10, revised August 1, 2021, indicated the purpose of documentation is to provide permanent record of the care and services the resident received during his/her stay at the assisted living community. Documentation will be signed or initialed and dated when care or services are provided. Documentation may be in paper or electronic format. Electronic signatures are acceptable. All documentation will remain a part of the resident's permanent record. The resident record is a legal document. Information will not be amended, removed or deleted. Direct care staff Services provided, and daily observation/monitoring of our resident's will be documented. TIME PERIOD TO CORRECT: Twenty-one (21)	0 730		

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0 730	Continued From page 6 Days	0 730		