Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL322706982M
Compliance #: HL322706425C

Date Concluded: April 13, 2026

Name, Address, and County of Licensee Investigated:
Benedictine Living Community – Byron
Madonna Summit
551 Byron Main Ct NE
Byron, MN 55920-2001
Olmsted County

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

Evaluator's Name: Christine Bluhm, RN
Special Investigator

Finding: Substantiated, facility 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 facility neglected the resident when it failed to notify the physician and family of the resident's elevated blood sugar readings. The readings were over 300 milligrams per deciliter (mg/dL) multiple days, and as high as 559. The resident was subsequently hospitalized with hyperglycemia (high blood sugar levels) requiring medications to lower blood sugar levels.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The resident's blood sugar readings were consistently high over an extended period of time and hospitalized with hyperglycemia. The resident's record lacked indication that the elevated readings were monitored and reported to the resident's physician or family.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident record, death record, hospital records, and employee personnel files. Also, the investigator observed general resident and

staff supervision of care and blood sugar collection and reporting practices during a recent visit to the facility.

The resident resided in an assisted living facility with dementia care. The resident's diagnoses included diabetes, a history of cancer and dementia. The resident's service plan included medication management, assistance with activities of daily living such as bathing, general hygiene, and meals. The resident's assessment indicated the resident had cognitive deficits but could communicate some basic needs to staff.

Review of a concern indicated the resident had symptoms of thirst, tiredness and abdominal pain and brought to urgent care. There, the resident's blood sugar was 473 and was instructed to see her primary doctor the following week. Later that day, the resident had atypical behaviors such as sleeping at the dinner table and reaching out into the air. A spot sugar check was 570. The resident was taken to the ER, admitted to the hospital and given insulin.

Review of the resident's medication administration record (MAR) included an order for daily blood sugar checks before breakfast. 27 consecutive readings were reviewed. One reading was less than 300, 11 readings between 300-400, 13 readings between 400-500 and two readings greater than 500. At that time, the resident was on diabetic oral medication, glipizide 2.5 mg daily.

The service plan indicated that licensed nursing was to provide medication reconciliation and medication checks by reviewing the MAR weekly to ensure compliance and whether follow-up is needed.

Review of a progress note indicated the resident was seen in urgent care for a suspected urinary tract infection (UTI). When the resident returned to the facility, family told them her blood sugar was elevated at the doctor's office and asked staff to recheck it, and it was 570. Family took the resident to the emergency room.

Review of a hospital note indicated the resident was admitted for hyperglycemia and metabolic encephalopathy (metabolism problems causing brain dysfunction) secondary to hyperglycemia. Other hospital testing for abdominal pain showed peritoneal cancer.

During an interview, the nurse manager stated she was not aware of the resident's elevated blood sugar readings. The nurse denied that staff informed her that the readings were high.

Another nurse stated there were no parameters in the resident's order when to contact the provider for the out-of-range blood sugar readings. She stated that if unlicensed staff did not verbally alert nursing, the nurses had no knowledge of the abnormal readings.

During interviews, unlicensed caregivers said they communicated the readings were high to nursing on multiple occasions. One caregiver stated she went to the nurses' office and told her

the blood sugar was “really high,” and the nurse responded that the resident was always high and to not give her any juice for breakfast.

During interview, a family member stated that they had concerns that the resident had a urinary tract infection (UTI). During the clinical visit, the urine screen was negative, but her blood sugar was in the upper 400’s. It was determined she could see her primary doctor the following Monday to work a plan to get the blood sugars under control. Family found out that the facility was checking the blood sugars daily and had been running high, but nothing had been done about it. They took the resident to the ER that night because she started hallucinating. She was hospitalized and was treated for hyperglycemia. Testing to rule other reasons out revealed she also had cancer. The resident returned to the facility and family took over the blood sugar testing and gave the resident her insulin. The resident passed away a few months later from cancer.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: Review of the resident’s updated MAR after the hospitalization indicated the order was updated with special instructions to notify the nurse/provider of blood sugars less than 70 or above 400 mg/dL.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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
Olmsted County Attorney
Byron City Attorney
Byron Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32270	A. BUILDING: _____ B. WING _____	C 02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY | BYRON	551 BYRON MAIN CT NE BYRON, MN 55920

(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 #HL322706982M/HL322706425C, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued issued for #HL322706982M/HL322706425C, 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 one of one 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		