Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356362962M
Compliance #: HL356365370C

Date Concluded: July 18, 2025

Name, Address, and County of Licensee Investigated:
Benedictine Asher Haus
717 1st Street North
Cold Spring, MN 56320
Stearns County

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

Evaluator's Name: Danyell Eccleston, 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(s):
The alleged perpetrators (AP)#1 and AP#2 neglected the resident when, on separate dates, AP#1 and AP#2 failed to contact the nurse regarding the resident's weight gain and the resident did not receive medication (furosemide/Lasix) that helped remove excess fluid from the resident's body. The resident experienced decreased oxygen levels due to fluid buildup and was sent the hospital for treatment.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure clarity and understanding of a provider's complex medication order by all unlicensed personnel who administered medication. The resident gained 13 pounds in three days and later experienced shortness of breath and an oxygen saturation of 53%. Staff members contacted emergency services and the resident went to the hospital for treatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff providing care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included chronic obstructive pulmonary disease (lung disease), congestive heart failure (condition when the heart cannot pump enough blood to meet needs leading to fluid buildup in the lungs and other body tissues), kidney disease, and dementia. The resident's service plan included daily weights, medication management, and assistance with reassurance. The resident's assessment indicated the resident needed cueing and reminders. The resident used oxygen continuously and needed reminders to breath in through her nose and have oxygen tubing in place.

Review of daily stand-up report, a document reviewed at shift changes, indicated the resident had a "new order for PRN (as needed) Lasix – no longer scheduled. Will be based on weight." The communication did not explain what the medication was used to treat, give further details regarding when to administer the medication, and did not refer to the medication as furosemide which is how it was listed in the medication administration record.

Review of the resident's medication administration record indicated furosemide 20mg to be given as needed. Special instructions indicated, "if 3 lb. increase overnight or 5 lb. increase in a week take 20mg." The medication administration record did not appear to refer to the medication as Lasix and did not give any further indication of what other symptoms the medication treated. The medication order did not include a baseline or goal weight.

Review of the resident's daily weight documentation indicated staff were to weigh the resident once in the morning and instructions indicated, "Daily weight first thing in the morning, before breakfast. If weight increases 3 lbs. overnight or 5 lbs. in a week. Update nurse." No other explanation of as needed medication or weight increase due to fluid overload included. Review of daily weight documentation indicated the resident's weights the week previous were higher than the dates in question, including 163 pounds, 164 pounds, 162.5 pounds, 161 pounds, 162 pounds. AP #1 weighed the resident on two consecutive days during the time in question, the first day the resident weighed 150 pounds and the second day the resident weighed 155 pounds. Then, AP #2 weighed the resident the following three days, the resident weighed: 155 pounds, 163 pounds, and then 162 pounds the day emergency services took the resident to the hospital.

Review of the resident's medication administration record and activity of daily living documentation indicated during the dates in question staff members, including AP#1 and AP#2, administered scheduled medications and completed daily living cares. The resident's medication administration record indicated the resident received as needed furosemide/Lasix five days prior to being sent to the hospital.

Review of facility internal review indicated the resident seemed well when she got up and later that morning indicated to staff, she did not feel well and was having difficulty breathing. Staff took the resident's oxygen saturation level, which was 53%, and turned up the resident's oxygen and contacted emergency services. The resident's weight had been up and down and there were two dates when the as needed Lasix should have been administered but was not given. The resident did not have any concerning symptoms until the day she was went to the hospital.

Review of AP #1's and AP #2's personnel file indicated both received medication administration training and passed competency testing for medication administration. Neither AP #1 nor AP #2 had received disciplinary action for prior medication errors.

During interview, a leadership member stated the facility recently underwent a change of electronic heath care record systems and the way the information displayed may not have been as clear or what staff were used to seeing. The leadership member also stated there was room for facility improvement to have better conversation with medical providers to be aware of the type of facility and type of staffing to have more appropriate order instructions for staff.

During interview, a nurse stated it is rare that a medication be given to a resident based on a vital sign (such as weight). However, all resident's daily tasks and cares have information on how to individually care for the resident. The nurse stated she was not aware of any previous care issues regarding AP #1 or AP#2.

During interview, AP #1 stated she weighed the resident promptly in the morning and did not realize she needed to go back and review the resident's previous weights and checking a weight to determine if a medication needed to be administered was not something she had not previously learned to do.

During interview, AP #2 stated she was not aware that she missed an opportunity to administer Lasix to the resident during the time in question. AP #2 stated the facility recently changed electronic health record systems and she did not see all the instructions regarding the medication and resident's weight, possibly due to not knowing she needed to scroll further in the computer system for further information. AP #2 stated the day in question the resident seemed well in the morning at the beginning of shift. Later in the morning, the resident pushed her pendant and was sweating and looked pale. AP #2 took the resident's vitals signs and the resident's pulse was off and her oxygen levels were low. AP #2 contacted another co-worker for assistance and 9-1-1 was called for the resident.

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, resident hospitalized.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrators interviewed: Yes.

Action taken by facility:
Internal review of incident conducted, staff educated, discussed complexity of order with provider.

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
Sterns County Attorney
Cold Spring City Attorney
Cold Spring Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35636	A. BUILDING: _____ B. WING _____	C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE ASHER HAUS	717 1ST STREET NORTH COLD SPRING, MN 56320

(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: #HL356363849C/#HL356362225M , #HL356365370C/#HL356362962M On July 4, 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 27 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL356365370C/#HL356362962M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of three 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	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.	