Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202863967M
Compliance #: HL202863868C

Date Concluded: October 19, 2026

Name, Address, and County of Licensee Investigated:
Benedict Homes
1340 Minnesota Boulevard SE 24
St. Cloud, MN 56304
Sherburne County

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

Evaluator's Name:
Katherine Barnhardt 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 facility neglected resident #1, resident #2 and resident #3 when facility staff failed to provide increased interventions and supervision after resident #3 displayed hypersexual behaviors toward resident #1 and resident #2.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect of resident #1, resident #2 and resident #3 was substantiated. The facility was responsible for the maltreatment. Facility licensed staff were made aware of resident #3's hypersexual behaviors toward female residents and staff. A medical provider recommended additional staff be added per shifts and/or one-to-one staffing to monitor and supervise resident #3 until resident #3 could be transferred to an all-male facility because medication and redirection were not effective. The facility failed to implement interventions or follow provider recommendations to protect female residents and facility staff from resident #3's hypersexual behaviors. Additionally, throughout the course of the investigation, multiple staff reported there were incidents that occurred between

resident #3 and other female residents, however, were not documented in resident records because facility leadership directed that memory care residents were consenting individuals and there was nothing staff were to do.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members, law enforcement and medical providers. The investigation included review of the resident record(s), medical provider records, pharmacy records, facility internal investigations, facility incident reports, personnel files, staff schedules, law enforcement reports, related facility policy and procedures. Also, the investigator observed unlicensed staff provide direct care.

Resident #1
Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included dementia. Resident #1's service plan included assistance with toileting, bathing, medication administration and meal reminders. Resident #1's assessment indicated the resident's dementia diagnosis posed a risk for the resident #1 to be abused by others, however lacked any specific instructions for unlicensed staff.

Resident #1's record indicated resident #3 entered resident #1's apartment uninvited and a resident-to-resident sexual incident occurred. Resident #1's record indicated unlicensed staff found resident #3 in resident #1's bedroom and resident #1 reported she had fought off resident #3. Resident #1's record indicated unlicensed and licensed staff observed resident #1 in bed with her brief rolled down and inward in the front and portions of her clothing displaced with her left breast exposed. Areas of redness were noted on resident #1's left breast and lower abdomen.

Resident #1's incident report indicated unlicensed staff observed resident #3 in resident #1's bedroom and resident #1 reported resident #3 had forced unwanted sexual contact. Resident #1 was described as having a blank expression, small areas of redness on left breast and lower abdomen. Resident #1 reported resident #3 got in her bed and she fought with resident #3. Resident #1 stated she did not feel safe and law enforcement was notified.

A law enforcement report indicated law enforcement was called to assist with unwanted sexual activity between two residents, and both residents were cognitively impaired. A law enforcement report indicated an unlicensed staff entered resident #1's room and observed resident #3 standing next to resident #1's bed. Unlicensed staff observed and reported resident #1 "had a terrified look on her face" and stated resident #3 tried to have sex with her. A law enforcement report indicated law enforcement reviewed facility video footage and the footage showed resident #3 enter resident #1's apartment. Resident #1 reported to law enforcement resident #3 was not invited into her apartment.

The facility lacked to provide unlicensed facility staff with specific measures to protect resident #1.

Resident #2
Resident #2 resided in an assisted living memory care unit. Resident #2's diagnoses included dementia. Resident #2's service plan included assistance with reminders for dressing, grooming, meals and activities. Resident #2's assessment indicated the resident's dementia diagnosis posed a risk for the resident to be abused by others, however lacked any specific instructions for unlicensed staff.

Resident #2's record indicated unlicensed staff found resident #2 backed into a closet in resident #3's room with resident #3 standing in front of resident #2 with pants and under garments down. Resident #2's blouse was undone, undergarments were up however, her pants were lowered. Unlicensed staff asked resident #2 if she was ok and wanted to leave with staff and resident #2 left resident #3's room with unlicensed staff. Resident #2's record indicated resident #2 stated to unlicensed staff she did not want that.

Resident #2's facility investigation summary indicated unlicensed staff observed resident #2 standing in resident #3's apartment. Resident #3's lower half was undressed and resident #2 was "fully dressed" with an unbuttoned shirt. Resident #2 reported resident #3 had touched her chest. Resident #2's facility investigation record indicated resident #3 denied inviting resident #2 into his apartment and denied sexual activity occurred. Facility investigation records indicated additional information was added to resident #2's internal investigation the next day when a medical provider informed facility licensed staff resident #2 reported she had been hurt between the legs by a man. Law enforcement was notified. Resident #2's facility investigation indicated one to one supervision was implemented "as possible" for resident #3.

A law enforcement report noted incident similarities in two police reports received in the same month that involved resident #1, resident #2, and resident #3. The report indicated information reported to facility staff on the day of the incident changed when resident #2 reported pain between her legs to a family member. Family requested law enforcement be called. Resident #2 was interviewed. A law enforcement report indicated resident #2 "seemed extremely hesitant" to talk about the incident and law enforcement felt it was due to her inability to recall the incident details. Resident #2 reported she was fully clothed, however, made a comment to the officer that referenced resident #3's digital penetration of resident #2. A law enforcement report indicated after that line of questioning resident #2 "shut down completely and stopped answering questions".

The facility lacked to provide unlicensed facility staff with specific measures to protect resident #2.

Resident #3
Resident #3 resided in an assisted living memory care unit. Resident #3's diagnoses included dementia. Resident #3's service plan included assistance with meal escorts, monitor for sexual inappropriateness, redirection and behavior interventions. Resident #3's assessment indicated

independence with most activities of daily living and sexually inappropriate behaviors. The assessment indicated resident #3 required a behavior management plan. Resident #3's behavior management plan directed staff to provide verbal redirection, call family for support, provide activity and utilize an as needed medication for increased anxiety.

Resident #3's record indicated five weeks before multiple resident-to-resident incidents occurred and hypersexual impulses were acted on by resident #3, unlicensed staff reported behavioral concerns to licensed staff. Unlicensed staff reported concerns for female residents and sexually impulsive behaviors toward staff to licensed staff. Licensed staff notified a medical provider of the increased episodes and reported safety checks and behavior monitoring were increased. Licensed staff added a service to monitor and document resident #3's hypersexual inappropriate behaviors twenty-four times daily (hourly), however, the service was scheduled for unlicensed staff twelve times daily (every two hours). Resident #3's record indicated when resident #3 was found in resident #1's room and after the first sexual assault complaint was filed; licensed staff adjusted the monitoring schedule to hourly. Resident #3's record indicated the second sexual assault complaint with resident #2 occurred seven days later and resident #3 discharged to an all-male facility the same day.

Resident #3's progress notes indicated the resident had a history of sexually inappropriate behaviors towards female residents and staff. Resident #3's progress notes indicated resident #3 attempted and kissed female residents, entered female resident rooms without consent, got into female resident beds without consent and inappropriately touched female staff. Progress notes indicated female residents reported feeling uncomfortable when resident #3 attempted to kiss and touch them. Resident #3 had multiple events of inappropriate sexual behaviors over a weekend toward three female residents and multiple female staff. Resident #3's progress notes indicated staff were instructed to monitor for changes in behavior and call family for support. Progress notes indicated licensed staff reported to a medical provider and safety checks were increased.

A medical providers communication one day after resident #1's incident and approximately six days before resident #2's incident with resident #3 indicated concern for female residents' safety and "advocated for additional staff members to be scheduled each shift" to maintain safety of female residents until resident #3 could be placed at an all-male facility. Additionally, a providers communication indicated "careful supervision, one to one", if able. Resident #3's behavior presented a "danger to numerous female residents who are not able to consent".

Staff schedule records indicated no additional staff were added to the schedule.

The facility lacked to provide unlicensed staff with specific measures to manage resident #3's hypersexual behaviors. The facility lacked to provide and implement recommended supervision to prevent resident #3's hypersexual incidents against multiple female residents and staff.

During an interview, resident #1 stated resident #3 entered her room uninvited and tried to have sex with her. Resident #1 stated they fought and resident #3 left her room when staff came in.

During an interview, unlicensed staff stated it would be difficult for resident #1 to defend herself due to pain and mobility and she did not have a call pendant to summon assistance. Unlicensed staff stated resident #2 was found in resident #3's closet and "she was scared, really scared." Unlicensed staff stated another female resident was not seen for a period of time and was found in resident #3's bed when resident #3's room was checked. Unlicensed staff stated resident #2 was "very vulnerable" and if someone asked her to go somewhere, she would. Unlicensed staff stated there were no instructions or intervention changes for staff to manage resident #3's inappropriate sexual behaviors until resident #2 was sexually assaulted.

During an interview, an unlicensed staff stated she found resident #2 in resident #3's room cornered in a closet with resident #3 standing in front of her with his pants and undergarments pulled down. Resident #2 answered yes when asked if she wanted to leave resident #3's room. Due to concerns with leadership response, an unlicensed staff stated several unlicensed staff went to facility leadership to express concern over what happened and asked if law enforcement should be called. Unlicensed staff were told no; leadership would investigate first. Leadership stated to the unlicensed staff resident #2 was fine and only her breast was touched. Unlicensed staff who witnessed the incident disputed leadership's finding. The next day family reported to resident #2's provider that resident #2 reported being hurt between the legs and law enforcement was notified.

During an interview, unlicensed personnel stated throughout the series of incidents with resident #1, resident #2 and resident #3 nothing was changed to address resident #3's hypersexual behaviors. Unlicensed staff would try to know where resident #3 was and know which female residents were vulnerable to resident #3. Unlicensed staff stated if resident #3 had not been seen in a while she would knock on resident #3's door. Unlicensed staff stated resident #2 had not been seen for a while and when staff searched for resident #2, she was found in resident #3's closet "really scared." Unlicensed staff stated resident #3 pursued resident #1, resident #2, and other female residents in the facility and resident #3 may have followed resident #1 back to her apartment when that incident occurred.

During an interview, a licensed staff stated incidents between residents were not consistently entered into resident records. Licensed staff stated leadership questioned her about documentation she entered into resident records regarding incidents and voiced concern "it could open a lot of legal doors if MDH decides to investigate." Licensed staff stated she had concerns about different residents and there were times she took it upon herself because she didn't agree with leadership about consent.

During an interview, clinical leadership stated assessments included behavior review, risk to self or others however, there was no specific question about risk of sexual behaviors toward others.

Clinical leadership stated the residents were considered able to consent to sexual behaviors based on the residents' BIMs score (an assessment that determines cognitive impairment level) and family approval. Clinical leadership stated the BIMs scores of resident #1 and resident #2 were moderate to severe cognitive impairment. Clinical leadership stated resident #1 and resident #2 were involved in a "severe event" with resident #3 and two other female residents were involved in "obviously less severe" events with resident #3. Clinical leadership stated concerns with resident #3's hypersexual behaviors were brought to licensed staff around mid-summer, and the facility attempted to implement the providers' recommendations, however, just one shift was able to be covered with additional staff.

During an interview, a family member of resident #2 stated facility leadership called and reported a consensual sexual incident occurred. A family member stated resident #2 was unable to defend herself, consent to sexual interactions, or make decisions for herself and that was the purpose of placing her in a memory care facility. The next morning the family member traveled from out of town and met with resident #2 and a medical provider. Resident #2 reported she was hurt between the legs by the man (resident #3). Law enforcement was called at the family member's request. A family member stated facility leadership stated 15-minute checks would be implemented for resident #2. (15-minute checks were not implemented) A family member stated family attempted to move resident #2 immediately, however, there were no openings in central Minnesota.

During an interview, a family member of resident #1 stated facility leadership called and informed family a non-consensual incident occurred, a gentleman was found in resident #1's room and law enforcement was involved "and that was about it". A family member stated, "I've had virtually no contact with anybody of significance after the incident".

In conclusion, the Minnesota Department of Health determined neglect of resident #1, resident #2 and resident #3 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not applicable

Action taken by facility:
Facility licensed staff conducted internal investigations.

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
Sherburne Attorney
St. Cloud City Attorney
St. Cloud Police Department

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 09/16/2026

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 ******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: #HL202863967M/#HL202863868C On September 16, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 24 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL202863967M/#HL202863868C, tag identification 0630, 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=I	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview, observation and record review, the licensee failed to update an individual abuse prevention plan (IAPP) with the required content for four of four residents (R1, R2, R3, R4) when R3 sexually touched R1, R2 and R4. The licensee failed to update R1, R2, R3 and R4's individual abuse prevention plans and implement specific measures to ensure R1, R2, R3, R4 and other residents were safe. The failure had the potential to affect the health and safety of all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 630		

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0 630	Continued From page 2 has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included dementia. R1's service plan dated May 13, 2026, included medication administration, assist of one for toileting, meal reminders, housekeeping and laundry. R1's Individual Abuse Prevention Plan and last assessment dated July 20, 2026, indicated R1 was at risk for abuse by other individuals due to a preference for self-isolation. Progress notes entered into R1's record indicated the following: - August 18, 2026, at 11:28 a.m., written by unlicensed personnel (ULP)-H, a male resident (R3) was witnessed in resident (R1) room. Staff reported that residents (R1) breast was exposed and her pants were rolled down. An undated internal investigation document indicated: - on August 18, 2026, at approximately 8:53 a.m., a male resident (R3) was observed entering a female residents (R1) apartment. At approximately 9:01 a.m., staff entered the apartment and found the male resident (R3) standing in the female residents (R1) bedroom. The female resident (R1) was found lying on her side with portions of her clothing/brief displaced and appeared to have a blank expression. The female resident (R1) reported the male resident	0 630		

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0 630	Continued From page 3 (R3) entered and that unwanted sexual contact had occurred. The female resident (R1) stated the male resident (R3) got in her bed and they fought. The female resident (R1) reported feeling unsafe. A skin assessment was completed and two small areas of redness were noted on breast and lower abdomen. Law enforcement was notified. - August 18, 2026, at 11:28 a.m., written by registered nurse (RN)-L, verbal confirmation Minnesota Adult Abuse Reporting Center (MAARC) report filed. (sexual assault R3 against R1) The facility lacked to provide and implement specific measures to protect R1 from R3. R2 R2's diagnoses included: Alzheimer's Disease. R2's service agreement dated July 13, 2026, included medication administration, meal reminders, bathing, housekeeping and laundry. R2's Individual Abuse Prevention Plan and assessment dated September 11, 2026, indicated R2 was at risk for abuse by other individuals due to dementia. Progress notes entered into R2's record indicated the following: - on August 25, 2026, at 1:07 p.m., written by ULP-D, an incident was witnessed around 9:20 a.m. with the resident (R2) and a male resident (R3). She (R2) was found in the male resident's (R3) room. She (R2) was backed into the closet, the male resident (R3) was standing in front of her with his pants and underwear pulled down to	0 630		

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0 630	Continued From page 4 his knees. Her (R2) shirt was unbuttoned and her pants were pulled down. She did have her underwear pulled up. RA asked resident if she (R2) would like to leave the room and she stated yes. Resident (R2) pulled up her pants and buttoned her shirt and followed the RA out of the room. RA asked resident if she was ok, she said yes. Resident (R2) stated that she wanted to be done with that man, he is different. She (R2) stated she did not want that. - on August 26, 2026, at 12:05 p.m., written by ULP-H, I was in conference room talking with the PCP (primary care provider) on a question about a resident (R2) when [R2's family] knocked on the door. She [R2's family] stated to the PCP that the resident (R2) told her that the man (R3) hurt her between her legs. She [R2's family] than stated to the PCP that she needs to know if the resident (R2) is safe here. An undated internal investigation summary indicated: - on August 25, 2026, at approximately 9:00 a.m., licensee staff observed R2 in R3's apartment. Staff observed R3 was not wearing pants or a brief. R2 was fully dressed, although her shirt was noted to be partially unbuttoned. At approximately 9:10 a.m., licensed assisted living director (LALD)-B interviewed R2 regarding the incident. R2 stated she had gone to R3's apartment and that they were "face to face". R2 reported R3 had touched her chest. R2 declined to meet with nursing staff. Due to ongoing concerns, one-to-one staff supervision implemented until planned discharge of R3 approximately four hours later. The licensee's internal investigation summary	0 630		

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0 630	Continued From page 5 lacked to include R2 was found cornered in R3's closet and that R2's pants were pulled down. - August 25, 2026, at 4:11 p.m., a Minnesota Adult Abuse Reporting Center (MAARC) report was filed. (sexual assault R3 against R2). Law enforcement was notified. On August 25, 2026, licensee leadership notified R2's representatives a consensual sexual incident occurred. The licensee failed to implement additional staffing and/or one-to-one supervision for R3 recommended by a PCP one week earlier. The licensee lacked to provide and implement specific measures to protect R2 from R3. R3 R3's diagnoses included: dementia R3's Service Plan dated May 1, 2026, included medication administration, meal escorts, housekeeping and laundry. R3's Individual Abuse Prevention Plan and last assessment dated May 22, 2026, indicated R3 was at risk to abuse others with assaultive behaviors, physical and verbal abuse. R3's individual abuse prevention plan indicated R3 had sexually inappropriate behaviors and asked staff to kiss and touch him inappropriately. Progress notes entered into R3's record indicated the following: - July 3, 2026, at 9:44 a.m., written by clinical nurse supervisor (CNS)-C, resident was found kissing a female resident. Resident (R3) was	0 630		

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0 630	Continued From page 6 separated from female resident who reported she was uncomfortable with the action. Resident was found a short time later attempting to enter a female residents (unknown resident) bed while the female resident was sleeping. - July 6, 2026, at 10:24 a.m., written by RN-K, resident (R3) had multiple events over the weekend and this morning of inappropriateness with three female residents (unknown female residents) and multiple female staff. Attempted to touch inappropriately, kiss, get in bed with a female resident (unknown female resident) and walking hallway unclothed from waist down. Agitated with redirection. - July 10, 2026, at 1:20 p.m., written by RN-K, resident (R3) continues to have increased episodes of sexual inappropriateness towards female residents. Safety checks increased. (Safety checks started July 6, four times daily. July 9, every four hours, July 10, started every two hours) - August 15, 2026, at 2:36 p.m., written by ULP-A, writer found resident (R3) in bed with [name] R4. [name] R4 had all her clothes on. [name] R3 had a tshirt and boxers on pulled down to his knees. Writer escorted [name] R4 out of the room. - August 18, 2026, at 10:57 a.m., written by ULP-H, gabapentin given due to sexually inappropriate behaviors with a female resident (R1). Resident (R3) was redirected back to room. Resident (R3) is now wandering the halls and is very nervous when talking to writer. Writer than saw [name] R3 and another resident (unknown female resident) kissing in the living room. - August 18, 2026, at 1:21 p.m., written by	0 630		

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BENEDICT HOMES	1340 MINNESOTA BOULEVARD SE SAINT CLOUD, MN 56304

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0 630	Continued From page 7 ULP-M, [name] R3 has been out of control. He has been trying to get close to most of the residents. He tried touching [named female resident] and [named female resident] didn't like that. He also touched [name] R1. Additionally, he also tried to kiss me as well and I am an RA. (resident caregiver/unlicensed personnel) - August 19, 2026, at 9:43 a.m., written by RN-K, resident (R3) has history of sexually inappropriate behaviors towards non-consenting female residents and staff members. On August 18, 2026, police were called to investigate a situation involving [name] R3 and a female resident (R1). [name] CNS-C and [name] LALD-B contacted about providers recommendation via secure email on August 19, 2026, at 9:13 a.m. Writer asked about efforts being made to find another placement for resident (R3) and concerns for female residents safety were brought up. Writer also advocated for additional staff members to be scheduled each shift to help provide redirection and help maintain safety of female residents until other placement is found for [name] R3. - August 19, 2026, at 10:47 a.m., written by RN-K, provider was notified of sexually inappropriate behaviors. Discussed concerns about resident behavior putting female residents at risk. Advocated for additional staff and all male facility placement for resident. Additionally, after further discussion with staff at the facility would advise careful supervision, 1:1 if able. Resident (R3) has had inappropriate sexual behavior directed at staff and numerous other residents. This behavior presents a danger to numerous female residents who are not able to consent. - August 21, 2026, at 6:22 p.m., written by CNS-C, resident (R3) was reported to be making	0 630		

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0 630	Continued From page 8 repeated attempts to kiss staff, request for staff to wash genitals, and made suggestive gestures. Resident (R3) redirected. - August 24, 2026, at 8:49 a.m., written by RN-K, last night staff reported resident (R3) was found in his room with female resident (unknown female resident). He (R3) was naked. The female resident (unknown female resident) redirected from his room and [name] R3 given as needed (PRN) medication. Three hours later at 11:19 p.m., it was reported [name] R3 came out of his room and was asking where the female resident (unknown resident) was, stating her name and room number. He (R3) attempted to locate her (unknown female resident) room. During this time, he (R3) was asking about the female resident (R1) involved in incident on August 18 stating her name (R1) and attempted to locate her room. Staff administered a second PRN medication. Concerned that [facility name] may not be appropriate setting for the resident. - August 24, 2026, at 9:20 a.m., provider notification written by CNS-C, resident (R3) has had increased events of attempted sexual interaction with female residents. Interventions have been placed to maintain resident safety as well as safety of other residents. - August 24, 2026, at 9:31 a.m., a provider response, I did recommend August 18, 2026, that effort be made to seek alternative placement in all male facility memory care. [facility name] is not an appropriate placement any longer and presents ongoing risk for [name] R3 and all female residents. I would again recommend the [facility name] expedite efforts to obtain alternative placement as soon as possible. Also recommended on August 18, 2026, encourage	0 630		

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0 630	Continued From page 9 additional supervision for him on the unit given repeated inappropriate behavior in spite of medication and re-direction. - August 25, 2026, at 11:11 a.m., written by ULP-D, around 9:20 a.m., did an hourly check as indicated to do so in my touch charts. Knocked on resident's (R3) door, annouced it was staff coming into room with apple juice for resident. Resident (R3) was facing the corner of the closet and there was a female resident (R2) in the corner facing him. He (R3) quickly pulled up his underwear then his pants. At the same time his phone began to ring. Asked resident to please answer the phone so ULP could go to aid of the female resident (R2). ULP asked female resident (R2) if she would like to leave the room and she said yes, she wanted to leave. Female resident (R2) was assisted to her room. As ULP was bringing the female resident (R2) back to her room, [name] R3 was following and seeking out the female resident (R2). Another staff intervened and redirected him. R3's progress notes did not include the names of females referenced throughout R3's progress notes. LALD-B and CNS-C stated the facility does not track resident-to-resident incidents as a category when the investigator requested an incident summary report for resident-to-resident incidents. LALD-B stated the expectation is staff report incidents to nurse leadership and management. The leadership team investigates and determines the outcomes of resident-to-resident incidents. R3's Individual Abuse Prevention Plan was not updated with specific measures to minimize the risk of reoccurrence following a sexual assault incident against R1and R2.	0 630		

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0 630	Continued From page 10 R3's Individual Abuse Prevention Plan was not updated with specific measures to minimize the risk of reoccurrence of hypersexual behaviors against R4. R4 R4's diagnoses included dementia. R4's service plan dated July 14, 2026, included medication administration, pain management, transfer assist, standby ambulation, meal reminders, housekeeping and laundry. R4's Individual Abuse Prevention Plan and last assessment dated September 15, 2026, indicated R4 was not at risk to abuse others, however, did not address risk of abuse from others. Progress notes entered into R4's record indicated the following: - July 3, 2026, at 3:05 p.m., written by RN-K, RA reported that a male resident (R3) attempted to kiss [name] R4 and was attempting to get her (R4) to follow him to his room. At approximately 8:30 p.m., the male resident (R3) was witnessed by staff entering [name] R4's room. Staff witnessed the male resident (R3) attempt to get in her (R4) bed. The male resident (R3) was redirected out of [name] R4's room. Did he get in your bed? Yeah. Did he make you uncomfortable? Yes. Did he touch you without your consent? Yes. R4's Individual Abuse Prevention Plan was not updated with specific measures to minimize the risk of reoccurrence following an inappropriate sexual behavior incident R3 against R4.	0 630		

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0 630	Continued From page 11 On September 22, 2026, at 1:00 p.m., a family member (FM)-F stated R2 was unable to consent or make decisions for herself and that was the purpose of placing R2 in a memory care facility. FM-F stated when CNS-C phoned family it was reported a consensual sexual incident occurred. FM-F went to the facility from out of town the next morning and met with R2 and a PCP. R2 reported to FM-F she was hurt between the legs by the man. FM-F demanded law enforcement be called. FM-F stated after law enforcement met with family, CNS-C and LALD-B stated 15-minute checks would be implemented for R2. (15-minute checks were not implemented on R2's services) FM-F stated family attempted to move R2 immediately, however, there were no openings in central Minnesota. On September 28, 2026, at 10:00 a.m., CNS-C stated she would need to review each of the female residents individual abuse prevention plans to see if any changes were made. CNS-C stated it would be typical to make changes as needed. CNS-C stated she had not received any reports of R3 forcing himself on any staff, but concerns with R3 were originally brought up around the July timeframe. Additionally, CNS-C stated one shift was covered with additional staff after the PCP made recommendations. CNS-C stated the facility does not track resident-to-resident incidents as a category and could not provide the investigator with a summary report of resident-to-resident incidents that occurred in the facility. On September 29, 2026, at 8:30 a.m., RN-K stated individual abuse prevention plans were typically reviewed every 90-days when assessments were done, however, was unaware of any specific measures provided to staff for the	0 630		

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0 630	Continued From page 12 management of R3's hypersexual behaviors. RN-K stated CNS-C sent R3's referral for placement to an all-male facility after R3 assaulted R2. On September 30, 2026, at 11:30 a.m., LALD-B stated the expectation was that individual abuse prevention plans be reviewed, however, she was unsure and relied on the clinical team for adjustments. LALD-B stated staff reported R3 was seeking comfort and gravitated toward female residents in the facility. LALD-B stated R4 was able to consent because the licensee had no cognitive testing that said otherwise and R4 did not have a provider consent determination. LALD-B stated one shift was covered with additional staffing and the licensee does not provide 1:1 monitoring. LALD-B stated the expectation is staff report incidents to nurse leadership and management. The leadership team investigates and determines the outcomes of resident-to-resident incidents. The licensee's Abuse Prevention Plan policy, revised March 2022, indicated identification of all events that may constitute maltreatment would be identified with correction and intervention. Individual Abuse Prevention Plans/Care Plans would be developed for each resident. The plan would contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided.	0 630		

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0 630	Continued From page 13 TIME PERIOD FOR CORRECTION: IMMEDIATE	0 630		
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. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure three of three residents reviewed (R1, R2, R3) were free from maltreatment. Findings include: On September 16, 2026, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360		