

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336021921M
Compliance #: HL336027300C

Date Concluded: June 10, 2026

Name, Address, and County of Licensee

Investigated:

Beehive Homes of Elk River
14282 Business Center Drive NW
Elk River, MN 55330
Sherburne County

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

Evaluator's Name: Ann Boutwell, RN
Special Investigator

Finding: Inconclusive

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 facility staff failed to supervise the resident in the shower resulting in a fall and a right femur break.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was inconclusive. Due to inconsistencies with service descriptions in the resident record and conflicting accounts of the incident, it could not be determined if maltreatment occurred. There was not a preponderance of evidence that staff failed to provide necessary supervision or services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff and a family member. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and history of falls. The resident's service plan included assistance with transfers, bathing setup, cues and behavior management. The resident's assessment indicated the resident had memory impairment, was a falls risk, and required an assist of one for bathing and transfers.

The incident report indicated unlicensed staff # 1 was providing a shower and the resident was anxious and agitated. The resident refused to have a towel placed on the floor to aid against a slippery floor. The resident stated she was done showering and wanted to stand up from the shower chair. The resident tried to stand up without assistance, fell and reported hip pain. After the fall, unlicensed staff notified nursing staff and was instructed to call 911. A falls report indicated unlicensed staff #2 drew a diagram of the fall scene and drew unlicensed staff #1 outside of the resident's bathroom. However, unlicensed staff #2 stated on the falls report that unlicensed staff #1 witnessed the fall.

Progress notes indicated nursing staff had communicated contradictory information to the resident's family. Nursing staff communicated to family unlicensed staff #1 had left the resident sitting on the shower chair to gather clothing different clothes at the resident's request and the resident fell. Nursing staff stated to family unlicensed staff #1 should not have left the resident alone.

Hospital records indicated the resident was seen at the emergency room and admitted to the hospital for surgery following the fall. The resident underwent right hip surgery and five days later was discharged to a transitional care unit. The resident did not return to the facility.

Review of facility documents included an assessment which indicated staff were to remain with the resident and provide direction for shower tasks and shower chair use. Other facility documents staff used for direction on how to provide care for the resident, indicated the resident needed assistance of one for showering, including, set up, queuing, and standby assist with areas of difficulty, but did not indicate to stay with the resident.

During an interview, unlicensed staff #1 had the resident check the water temperature and tried to put a towel down by resident's feet twice, however, each time the resident kicked the towels away. Unlicensed staff #1 explained to the resident towels on the floor would prevent her feet from slipping. Unlicensed staff #1 assisted the resident with showering and directed the resident not to stand because of the resident's poor balance. The resident attempted to stand by herself multiple times and unlicensed staff #1 provided reminders not to stand. The resident took her right hand and tried to grab the grab bar and the hand-held shower head from unlicensed staff #1's hand. The resident began to slide, lost her balance, and fell. Unlicensed staff #1 stated she tried to slow the resident's fall. Unlicensed staff #1 stated she kicked the shower chair out of the way, and it made a loud sound, unlicensed staff #2 heard the sound and

came to assist. A licensed practical staff was called and unlicensed staff #2 was instructed to call 911. Licensed practical staff directed unlicensed staff #1 to complete an electronic incident report. After the fall report and incident report were completed, unlicensed staff #1 stated there were discrepancies with the reports and what she reported happened the day of the incident. Unlicensed staff #1 stated she did not leave the resident alone.

During an interview, unlicensed staff # 2 stated she was in the hallway, heard a loud noise and when she entered the resident's room observed the resident on the shower floor. Unlicensed staff #1 was heard telling the resident she was not to get up off the shower chair. Unlicensed staff #2 stated the resident was bleeding from her head. Unlicensed staff #1 stayed with the resident and unlicensed staff #2 alerted another staff member to call a licensed practical staff. A licensed practical staff member instructed staff to call 911. Emergency services arrived and transported the resident to the hospital. Unlicensed staff #2 stated could not specifically remember where unlicensed staff #1 was positioned when she entered the resident's room.

During an interview, nursing staff stated she was called when the resident fell. Staff reported the resident hit her head and complained of hip pain. Nursing staff directed unlicensed staff call 911. Licensed practical staff stated her understanding of unlicensed staff #1's statement at the time of the fall was the resident did not want to wear clothing already in the bathroom. Nursing staff stated unlicensed staff #1 told the resident to stay seated while she turned to get different pants. Nursing staff stated unlicensed staff #1 reported to her the resident stated she did not need help, stood up, slipped and fell in the shower. Nursing staff contradicted an earlier statement and said unlicensed staff #1 must have been in the bathroom because she saw the resident's hand slip on the grab bar.

During an interview, nursing leadership stated the fall incident was investigated. Unlicensed staff #1 was in the bathroom with the resident and the resident's clothes were on a wheelchair by the sink. When unlicensed staff #1 turned toward the wheelchair, the resident stood up, placed her hand on a grab bar and the resident's hand slipped. The resident fell. The resident hit her head and fell on her hip. Nursing leadership stated the resident had no prior falls at the facility.

During an interview, a family member stated she was notified the resident had a fall, hit her head, complained of hip pain, and was transported to the hospital. A family member stated the resident reported she got up, fell, started to scream, and staff came running. Facility staff provided contradictory information about the incident. A family member stated the resident had a good memory about things a long time ago however, could not tell you what she had for supper three days ago.

In conclusion, The Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.

"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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: No, transferred to a transitional care unit.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: No, not applicable.

Action taken by facility:

Resident will remain supervised at all times while in the shower/bathroom.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/22/2026
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEEHIVE HOMES OF ELK RIVER	STREET ADDRESS, CITY, STATE, ZIP CODE 14282 BUSINESS CENTER DRIVE NW ELK RIVER, MN 55330
---	--

(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	<p>Initial Comments</p> <p>On April 22, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL336027300C/#HL336021921M. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____