Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL351251160M
Compliance #: HL351255260C

Date Concluded: May 21, 2026

Name, Address, and County of Licensee Investigated:
BeeHive Homes of Maple Grove
14901 Weaver Lake Road
Maple Grove, MN 55311
Hennepin County

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

Evaluator's Name: Lena Gangestad, 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 she sustained an injury of unknown origin and was later found resulting in a bump on her forehead and bruised area of her right side of face. The resident later was admitted to the hospital and diagnosed with pelvic, rib, and thoracic spine fractures.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. While the resident was found with a bump on her head during morning care, the injury was immediately reported to the nurse and the resident's family. Staff interviews indicated staff were providing regular supervision and safety checks consistent with the resident's care needs. When the injury was identified, it was identified as a potentially new condition, and appropriate follow-up care was arranged.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records,

internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses included dementia. The resident's service plan included assistance with all activities of daily living. The service plan also included every two-hour safety check.

A concern arose when during the provision of morning care, the caregiver observed a bump on the resident's head. The caregiver immediately reported the finding to the director of nursing and the nurse on duty. The nurse then notified the manager, and the resident's family was informed thereafter.

Hospital records indicated the resident had pelvic, rib, and thoracic spine fractures, however these fractures were described as non-acute and/or age-indeterminate indicating it was unclear how long ago they occurred.

During an interview, the manager stated she was notified by the unlicensed caregiver regarding the bump on the resident's head. Upon receiving the report, she contacted both the evening and overnight staff to determine whether anyone was aware of how the injury occurred. One overnight staff member reported she had completed routine safety checks and observed the bump on the resident's head. The staff member stated she asked the resident about the injury, and the resident reported that she had fallen the previous day. When the manager asked why the injury had not been reported, the overnight staff member said she believed the bump was from an older injury. The manager stated the morning staff also noticed the bump while preparing the resident for the day and reported the finding. She stated staff conducted safety checks every two hours for all residents in the memory care unit.

During the same interview, the manager stated the exact cause of the head injury was unknown. She guessed the resident might have struck her head on the bedside table. She also said the resident had previously used a different bed.

During an interview, the nurse manager stated the resident was capable of getting out of bed and knew how to use her pendant. The resident had a history of frequent falls. On the day of the incident, the hospital contacted the facility regarding fractures identified in the resident. The nurse manager stated hospital staff indicated the fractures may have been old, as the resident had not complained of pain during a prior hospital visit. The nurse manager stated the head injury may have occurred overnight as the resident struck her head on the nightstand. She further indicated the fractures were likely related to multiple falls which had occurred before the head injury was discovered.

During an interview, the overnight unlicensed caregiver stated when she arrived for her shift, the resident was already in bed. During routine checks, she observed a bump on the resident's head and asked the resident about it. The resident stated she had fallen the day before. The

caregiver said she did not know the injury was recent and therefore did not report it. She also said she had not previously worked with the resident and was unfamiliar with her baseline condition. The caregiver stated if she had recognized the injury as new, she would have reported it immediately.

During an interview, the family member stated the resident had experienced multiple falls in the weeks preceding the incident. However, the fall associated with the bump on the resident's head was the event that led to hospitalization. The family member stated she had no concerns regarding the care provided and believed the staff had done an exceptional job caring for the resident. The family member further stated following the resident's initial fall, she was sent to the hospital and discharged the same day. At that time, the family was unaware of any fractures. It was only after the resident returned to the hospital following the discovery of the bump on her head that imaging studies revealed multiple fractures.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility started an internal investigation. They sent the resident to the hospital for further evaluation. Following the incident, the Nurse Manager revised the resident's care plan to include increased toileting interventions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35125	A. BUILDING: _____ B. WING _____	C 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF MAPLE GROVE	14901 WEAVER LAKE ROAD MAPLE GROVE, MN 55311

(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 On April 15, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL351251160M/HL351255260C. No correction orders are issued.	0 000		