Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313502241M
Compliance #: HL313501204C

Date Concluded: October 14, 2024

Name, Address, and County of Licensee Investigated:
Beehive Homes of Duluth
4014 Trinity Road
Duluth, MN 55811
St. Louis County

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

Evaluator's Name: Michele Larson, 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 the resident when they failed to provide the resident with the required supervision and assistance needed for toileting and transferring and as a result, the resident fell four times within five days. One fall resulted in a fractured skull and brain bleed that required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the treatment. The resident was assessed as needing staff assistance with ambulation, toileting and transferring however, those services were not communicated and completed by staff. As a result, the resident fell four times resulting in a brain bleed and skull fracture.

The investigator conducted interviews with facility staff members, including nursing staff and the resident's family member. The investigation included review of the resident's facility record,

hospital records, home health agency physical therapy record, facility incident reports, and related facility policy and procedures. Also, the investigator observed direct resident cares during her onsite investigation.

The resident resided in an assisted living memory care facility. The resident's diagnoses included acute and chronic subdural hematoma (blood collected between the brain and skull), and orthostatic hypotension (blood pressure suddenly drops when standing from a sitting or lying position.) The resident's services indicated the resident required staff contact guard assist (staff must have their hand on the resident at all times to steady their balance), a gait belt and walker to ambulate. Due to the resident's unsteadiness and decreased strength, the resident required supervision to ensure safety when transferring and toileting during the day and night. The resident was unable to consistently use the call pendant.

A fall incident report indicated one evening the resident had an unwitnessed fall while attempting to put her pajamas on for bed. The resident sustained a dime-sized rug burn on her left elbow.

A fall incident report indicated 42 hours later; the resident was found lying on the floor just outside her bathroom. The resident told staff she slipped while going to the bathroom. The resident sustained a laceration to the left back side of her skull (occipital area). Staff noted a smear of blood on a bathroom cabinet along with a pool of blood on the bathroom floor. Staff cleaned the head laceration, and a pressure bandage was applied to the resident's open head wound. The facility implemented a fall pad to be on at all times.

The following day, a fall incident report indicated the resident fell in her apartment when attempting to self-transfer from the recliner and hit her head. The fall was unwitnessed.

The next day, a fall incident report indicated the resident had another unwitnessed fall in the resident's apartment when the resident attempted to self-transfer. The resident told staff her head struck the floor when she fell. The resident complained her head hurt.

A progress note indicated two days after her last fall, the resident's family member took the resident to the emergency room to have the resident's chest x-rayed due to her ongoing respiratory symptoms. The hospital recommended a computed tomography (CT) scan on the resident's head due to the resident's recent falls with head injuries. The resident was diagnosed with two brain bleeds, an approximate three-day old skull bone (occipital) fracture in addition to a respiratory infection. The resident was admitted to the hospital for observation. A follow-up CT scan indicated the resident had no improvement from her previous scan.

The resident's hospital record indicated the resident' provider documented, "We really need to work on avoiding another fall. Apparently, there is a higher level of care available where she lives." The resident spent three days in the hospital before she was discharged back to the facility.

The resident's record lacked evidence facility staff provided the resident with contact guard assistance during ambulation and lacked evidence a toileting schedule including frequency to assist the resident, was implemented. The resident's fall interventions included a toileting schedule as needed, assist with transfers as needed and did not include the frequency the resident required staff assistance. In addition, staff were directed to encourage the resident to press the call pendant when needing staff assistance even though the facility had determined the resident was unable to use the pendant properly.

When interviewed, a staff member stated the resident easily became off balance, stating the resident would try and sit down on the toilet seat before she was actually sitting on the toilet. The staff member stated the resident was unable to tell how far or close she was to the toilet seat before she sat down.

When interviewed, the facility nurse stated the resident was always a fall risk and sustained many falls stating most falls occurred while the resident attempted to toilet herself. The facility nurse stated although the facility could not provide 1:1 supervision they "obviously" would supervise the resident to make sure she was okay. The facility nurse stated she was unsure if the resident knew how to use her call pendant. The facility nurse stated messages were sent out to staff whenever a resident fell notifying staff of changes made to service plans.

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. Unable to interview due to the severity of her cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:

The facility completed fall incident reports.

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
St. Louis County Attorney
Duluth City Attorney
Duluth Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31350	A. BUILDING: _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF DULUTH	4014 TRINITY ROAD DULUTH, MN 55811

(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: #HL313501204C/#HL313502241M On July 17, 2024, 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 37 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL313501204C/#HL313502241M, tag identification 2310 and 2360.	0 000	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.	

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02310	Continued From page 1	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to communicate to staff and implement new fall interventions that addressed the increased needs for mobility and transfer assistance to reduce the risk of falls for one of one resident (R1) with record reviewed. The resident fell and fractured her skull while attempting to toilet herself. This failure caused actual harm to R1. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The National Library of Medicine (NLM)/National Institute of Health (NIH) website, http://www.ncbi.nlm.nih.gov, Utilize Principles of Mobility to Assist Clients, last updated December 2022, defined the definition of "Independent," as a resident who required no assistance to move from one place to another. The definition of	02310		

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02310	Continued From page 2 "Contact-Guard-Assist (CGA)," indicated one assistant "must" have their hand on the client at all times to steady their balance. R1's record was reviewed. R1 was admitted to the facility on January 10, 2023. R1's diagnoses included but were not limited to mild cognitive impairment with memory loss, acute (new) intracranial subdural hematoma (serious condition that occurs when blood pools between the brain and the skull), chronic (long term) subdural hematoma, and orthostatic hypotension (sudden drop in blood pressure when standing up from sitting up or laying down.) R1's service plan additions and changes document indicated on March 2, 2023, a service was implemented indicating R1 would receive daily contact guard staff assistance with a gait belt when walking. R1's care plan dated January 11, 2024, indicated R1 received assistance with getting dressed, meals, and medication management. Due to her unsteadiness, R1 required supervision to ensure the resident's safety when transferring. R1 required daily toileting assistance. The care plan failed to direct staff on the frequency R1 required staff assistance with transferring and toileting R1's assessment dated January 11, 2024, indicated R1 was unable to use her call pendant appropriately due to her dementia diagnosis. R1 had decreased muscular coordination and was a high fall risk. R1's mobility section in the assessment indicated R1 was "independent-could transfer without help," and "independent-walked without assistance," even though her service plan indicated she required contact guard assist using a gait belt. Fall	02310		

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02310	Continued From page 3 interventions included continue hourly safety checks, keeping pathways free and clear of clutter, assisting the resident with transfers as needed, continue toileting schedule as needed, continue proper non-slip footwear to be used at all times, adequate lighting, continue daily tidies, and encourage the resident to press the call pendant when needing staff assistance. R1's assessment did not accurately reflect R1's need for contact guard assistance using a gait belt with transfers and walking assistance or a frequency for transfer and toileting assistance. R1's fall incident report dated February 14, 2024, at 1:40 p.m., indicated R1 was found lying on the floor just outside her bathroom. R1 told staff she slipped while going to the bathroom. R1 sustained a laceration to the left back side of her head (occipital area). Staff noted a smear of blood on a bathroom cabinet along with a pool of blood on the bathroom floor. R1's head laceration was cleaned and a pressure dressing was applied to her open head wound. A section titled "Additional Insights into the Fall," indicated R1 had an ongoing, unproductive cough the past two days due to an unknown respiratory virus. The facility implemented a fall pad to be on at all times while R1 was ill. R1's progress note dated February 18, 2024, at 1:47 p.m., indicated R1's family member took R1 to the emergency room (ER) to x-ray R1's chest due to a portable x-ray company's inability to perform the in-house facility x-ray that day. The hospital performed a computed tomography (CT) scan on R1's head due to R1's recent falls. R1's progress note dated February 18, 2024, at 2:14 p.m., indicated R1 was diagnosed with respiratory Syncytial Virus (RSV), two brain	02310		

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02310	Continued From page 4 bleeds, and a fractured skull believed to be three days old. R1 was admitted to the hospital for observation. A follow-up CT scan indicated there was no improvement from her previous CT scan. R1's hospital record dated February 19, 2024, indicated R1 was diagnosed with an acute on chronic brain bleed (subdural hematoma), acute fracture of her left skull (occipital) bone, and RSV. R1's family member indicated R1 required more assistance the past week. R1's hospital provider documented, "We really need to work on avoiding another fall. Apparently, there is a higher level of care available where she lives." R1's progress note dated February 21, 2024, at 11:53 a.m., indicated R1 was discharged from the hospital and back to the facility. Post-hospital interventions included fall pad on at all times, and a sign in R1's room to remind her to press her call pendant for assistance. R1's progress note indicated due to her recent illness and weakness R1 required stand-by assist of one staff person whenever she used her walker. R1's service delivery record dated February 2024 lacked documentation R1 received her required toileting schedule or supervision with transfers until two days after she was discharged from the hospital following her brain bleeds and fractured skull. The licensee failed to communicate to staff R1's required need for staff assistance. During an interview on August 13, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated although R1 was always considered a fall risk R1's level of care never increased until February 23, 2024. CNS-B stated staff followed residents' service plans to determine what services to provide the residents and stated documented	02310		

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02310	Continued From page 5 provided services were listed in resident's service delivery records. During an interview on August 22, 2024, at 11:16 a.m., unlicensed personnel (ULP)-C stated R1 easily became off balance stating R1 would try and sit down before she actually seated on the toilet seat. ULP-C stated, "I don't think she could tell how really far and close she was to the toilet." The licensee policy titled, Fall Prevention and Reduction, updated March 15, 2022, indicated the registered nurse (RN) would evaluate potential fall interventions to reduce or eliminate the resident's risk for falls, if the RN believed the resident was at risk. TIME PERIOD TO CORRECT: Seven (7) days.	02310		
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: The facility failed to ensure one of one resident(s) 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		

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