Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336024303M
Compliance #: HL336027190C

Date Concluded: March 28, 2023

Name, Address, and County of Licensee Investigated:

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

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

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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 perpetrator (AP) verbally abused a resident when she was witnessed verbally abusing a resident by swearing and yelling at the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. Facility staff observed the AP yelling and swearing at the resident. Although the AP denied the allegation of yelling and swearing at the resident, the AP had a history of inappropriate conduct with

residents as well as a history of using abusive, humiliating conduct with residents which was reported by multiple staff. A preponderance of evidence indicated the incident likely occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records including assessments, progress notes, care plan, service agreement, staff schedules, facility incident reports, training records, and AP's personnel records including disciplinary action, coaching, facility investigation documentation, and policies and procedures. In addition, observations of the resident were made.

The resident resided in a secured assisted living dementia care facility with diagnoses including dementia with behavioral disturbances, chronic lymphocytic leukemia, and degenerative disc disease, and received hospice services for end-of-life care.

The resident's assessment and care plan indicated the resident was cognitively impaired and oriented to herself only. The care plan indicated the resident was dependent on staff for all activities of daily living including mobility, transfers, dressing, personal hygiene, and incontinence care. The resident assessment indicated she was not able to understand expectations or follow direction from staff.

A facility email communication written by a facility staff member indicated the AP swore at the resident "get your ass up, I am not fucking playing".

The facility investigation of the incident indicated the staff witness was in the hallway and reported hearing the AP swearing at the resident, so the staff member entered the room to intervene. When the staff member entered the room, the AP stated, "She [resident] won't get her fucking ass up, and it's pissing me off!" The AP then yelled at the resident "Shut up, I am trying to take care of you".

A review of the AP's personnel files included multiple incidents reported by five different facility staff members during her employment at the facility which included the AP recorded a resident with cognitive impairment as she coached the resident to repeat a statement of profanity, then sent the recording to two other staff; The AP was reported for using inappropriate language in front of resident's, calling a resident "meatball", and making derogatory comments about the smell of a resident while providing incontinence cares. The AP told one resident who was anxious and fixated on where her car was, that another resident had stolen her car, causing the residents to have increased agitation and argue. The AP had a history of aggressively confronting staff who reported concerns about her conduct, and accused one staff member of reporting her, and called them a "little bitch" in front of residents. The AP's personnel file also indicated the AP told a married couple that a staff member was sexually active prior to marriage because it would be upsetting to the couple and against their beliefs.

When interviewed a staff member stated the AP had no sense of appropriate boundaries, and some interactions with the residents were abusive. The staff stated the AP often swore loudly while talking about her personal life in front of resident's. The staff stated the AP had inappropriate conduct with male resident's and would tell them they were "her boyfriend, and she loved them". The staff stated there was another incident when the AP inappropriately applied heavy exaggerated makeup on a resident by drawing dark heavy eyebrows and applied heavy blush in a humiliating manner to a non-verbal, cognitively impaired resident, who did not normally wear makeup. The staff stated the AP laughed at the resident while she applied the makeup.

When interviewed facility leadership stated the reporter was a reliable source and was very upset by the AP's actions. The leadership staff stated that with the AP's history of inappropriate conduct and use of profanity with residents, they believed the verbal abuse occurred.

When interviewed the AP denied the allegation.

In conclusion, abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: No- unable.

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility provided education coaching and follow up when incidents occurred. Staff reported the concern of potential abuse, the facility investigated the incident, the AP is no longer employed by the facility. The facility provided all staff re-education on identifying and reporting maltreatment.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sherburne County Attorney
Elk River City Attorney
Elk River Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33602	A. BUILDING: _____ B. WING _____	C 02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES	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	Initial Comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER LICENSING 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: #HL336024303M, and # HL336027190C On February 28, 2023, 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 23 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued. The following correction order is issued for #HL336024303M, and # HL336027190C, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial	02360		

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02360	Continued From page 1 exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one of one residents reviewed, (R1) was free from maltreatment. R1 was abused. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and a facility staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	