



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 28, 2026

Licensee
The Geneva Suites
6200 Parkwood Road
Edina, MN 55436

RE: Project Number(s) SL33870016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" being more prominent than the last name "DeVries".

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33870	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2026
NAME OF PROVIDER OR SUPPLIER THE GENEVA SUITES		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 PARKWOOD ROAD EDINA, MN 55436			
(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33870016-0 On August 17, 2026, through August 20, 2026, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents: all of whom received services under the Assisted Living license. An immediate correction order was identified on August 19, 2026, issued for SL33870016-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing at all times to meet the reasonably foreseeable unscheduled needs of each resident as required by the resident's assessment and/or service plan for two of two residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470			

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's Weekly Staff Schedule dated the week of August 16, 2026, indicated the following: -two unlicensed personnel (ULP) scheduled for 6:00 a.m., to 2:00 p.m., shift; -two ULP scheduled for 2:00 p.m., to 10:00 p.m., shift; and -one ULP scheduled for 10:00 p.m., to 6:00 a.m. The licensee's Assisted Living Staffing Plan last reviewed July 26, 2026, indicated there were a total of five direct care staff scheduled daily. R3 R3 was admitted to the licensee on August 4, 2025, with diagnoses including dementia, hypertension, fracture of right shoulder girdle, muscle weakness, and spinal stenosis. R3's Change of Condition Assessment completed on August 10, 2026, indicated R3 required assist of two for transfers with EZ stand to the toilet. R3's Master Care Plan completed on August 17, 2026, (during the survey) indicated R3 transferred using Sara Steady lift with assist of one person for transfers and toileting needs. R5 R5 was admitted to the licensee on November 14, 2024, with diagnoses including multiple	0 470			

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0 470	Continued From page 3 sclerosis (MS), Hashimoto's thyroiditis, vitamin D deficiency, Graves' disease, and unspecified lack of coordination. R5's Clinical Update Assessment dated August 17, 2026, indicated R5 needed assist of two for transfers with a Hoyer lift. The assessment indicated R5 was assist of one with the Hoyer in case of emergency. The assessment also indicated that R5 was toileted with assist of two by using the Hoyer during daytime hours, and assist of one person during overnight hours, using bed pan as needed. On August 18, 2026, at 12:22 p.m., clinical nurse supervisor (CNS)-C stated R5 would not use the toilet at night because they did not want to get up at night to go to the bathroom, if R5 wanted to go to the bathroom at night, staff could call the float staff. On August 18, 2026, at 12:25 p.m., the surveyor inquired how they would help R5 out of the building in case of emergency at night. Licensed assisted living director (LALD)-D stated in case of emergency they would not want staff to do a two person assist if there was fire in the building, instead, they would rather have them do a one person assist and get more people out of the building. LALD-D stated this was indicated under their emergency evacuation plan in the emergency preparedness plan (EPP) and it was also on the resident assessment. LALD-D stated the topic was also discussed and determined at their EPP meeting, that they would rather get as many people as they could out of the building, it would be better for staff to divide and conquer. On August 18, 2026, at 12:50 p.m., R5 stated they did not use a bed pan they used briefs, and	0 470			

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0 470	Continued From page 4 with MS they had bladder issues, not bowel. R5 stated staff must call another helper at night if they have to go to the bathroom, and they would rather sleep at night and not bother to go to the bathroom. The surveyor asked R5 if they get changed at night and R5 stated if they needed to be changed at night, they would call for help. In case they wanted to use the bathroom for bowel at night then staff would have to call another person for help but that never happened in the past. On August 19, 2026, at 11:58 a.m., the surveyors observed ULP-A and ULP-B transfer R3 using a gait belt from a lifting recliner in the living room to a sit-to-stand style mechanical lift. The surveyor asked if the process always involved two staff members. One ULP stated, "not all the time but that's how we were instructed". On August 19, 2026, at 2:48 p.m., CNS-C stated, "it did not occur to me that in a facility where we have six residents as compared to a huge facility, I do not think to staff one person for overnight is a grave situation." The licensee's Staffing, Scheduling, and Staffing Shortage Contingency policy revised June 1, 2026, read, "Staffing will be sufficient at all times to meet each resident's assessed and service-plan needs. The following minimum availability requirements apply: - o A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. - o One or more persons responsible for responding to resident requests for assistance	0 470			

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0 470	Continued From page 5 with health or safety needs will be available 24 hours per day, seven days per week. Such persons must be awake; located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; capable of communicating with residents; capable of providing or summoning the appropriate assistance; and capable of following directions. o Staff will have access to an on-call registered nurse 24 hours per day, seven days per week. o During the hours of 10:00 p.m. to 6:00 a.m., direct-care staff shall respond to a resident's request for assistance with health or safety needs within a reasonable amount of time, consistent with Minnesota Rule 4659.0180, subp. 6, and Minnesota Statutes § 144G.41, subd. 1(12)(ii). Routine Two-Person Assistance and Transfers. When a resident's assessment and service plan require two direct-care staff for a transfer or other assistance, two direct-care staff will be scheduled and available at all times for the resident's scheduled reasonably foreseeable and unscheduled needs. The facility will organize assignments and staffing so these needs can be timely met. The phrase "within a reasonable amount of time" in § 144G.41, subd. 1(12)(ii), and Minnesota Rule 4659.0180, subp. 6, applies to staff response to resident requests for health or safety assistance; it does not replace the requirement in Minnesota Rule 4659.0180, subp. 5, that two direct-care staff be scheduled and available when the resident requires two-person assistance. Emergency Evacuation. During an actual fire, disaster, or other emergency requiring evacuation, staff will follow the facility's written emergency disaster and evacuation plan and will respond promptly and effectively to the immediate	0 470			

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0 470	Continued From page 6 life-safety situation. Depending on the resident's condition, location, evacuation method, available staff, and immediacy of the danger, one or two trained staff may initiate or carry out emergency evacuation assistance while additional staff or emergency responders are summoned. The goal during an emergency evacuation is to move residents from immediate danger as quickly and safely as circumstances permit. This emergency evacuation procedure does not change a resident's assessed two-person assistance requirement for routine transfers or other nonemergency care. 3. 24-Hour Daily Staffing Schedule and Posting The Clinical Nurse Supervisor, or a qualified designee acting under the facility's staffing process, will ensure a 24-hour daily staffing schedule is maintained. The schedule will identify: - o Each direct-care staff member scheduled to work, including all work shifts, days, and hours worked. - o Each direct-care staff member's resident assignments or work location. At the beginning of each work shift, the daily work schedule will be posted in a central location accessible to staff, residents, volunteers, and the public. Resident assignments and other information protected from public disclosure will be redacted from the posted version. Schedule changes, trades, agency coverage, call-ins, and other changes that affect actual staffing will be reflected in the facility's staffing records so the schedule accurately documents who worked and where they were assigned." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			

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0 480	Continued From page 7	0 480			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480			

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0 480	Continued From page 8 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 17, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480			

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0 480	Continued From page 9 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=E	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 and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for four of five residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 630			

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0 630	Continued From page 10 The findings include: R1 R1 was admitted to the licensee on February 17, 2025, with diagnoses that included down syndrome. R1's signed Service Plan dated April 7, 2025, indicated R1 received services for bathing, dressing, grooming, medication administration, meal assistance, and housekeeping. R1's IAPP completed on August 18, 2026, indicated R1 was at risk to be abused due to cognitive impairment. R1's IAPP did not contain a specific measures to minimize the risk of abuse. R2 R2 was admitted to the licensee on September 25, 2024, with a diagnosis of type 2 diabetes mellitus. R2's unsigned Master Care Plan updated on August 17, 2026, indicated R2 received services for bathing, dressing, ambulation, transfer, medication administration, and meal assistance. R2's IAPP completed on August 17, 2026, indicated R2 was at risk to be abused and R2 was able to report abuse. R2's IAPP did not contain specific measures to minimize the risk of abuse. R3 R3 was admitted to the licensee on August 4, 2025, with diagnoses that included dementia and hypothyroidism. R3's unsigned Master Care Plan updated on	0 630			

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0 630	Continued From page 11 August 17, 2026, indicated R3 received services for toileting, grooming, bathing, dressing, ambulation, transfer, medication administration, and meal assistance. R3's IAPP completed on August 17, 2026, indicated R3 was at risk to be abused physically, verbally, emotionally, financially, and sexually. R3's IAPP did not contain specific measures to minimize the risk of abuse. R4 R4 was admitted to the licensee on June 20, 2025, with diagnoses that included nontraumatic intracerebral hemorrhage and type 2 diabetes mellitus. R4's unsigned Master Care Plan updated on August 18, 2026, indicated R4 received services for toileting, grooming, bathing, dressing, ambulation, transfer, and medication administration. R4's IAPP completed on August 18, 2026, indicated R4 was at risk to be abused due to cognitive impairment. R4's IAPP did not contain specific measures to minimize the risk of abuse. On August 20, 2026, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated they did not have the specific measures listed on the IAPP, but specific measures were listed in the service plan. The Licensee's 6.05 Individual Abuse Prevention Plan policy dated June 10, 2024, indicated an Individual Abuse Prevention Plan will be developed for each resident and will be based on available information from the resident, the resident's representative when applicable, assessments, service planning, medical or other	0 630			

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0 630	Continued From page 12 records, staff observations, and other reliable information known to the facility. The IAPP will contain an individualized review or assessment of: a. The resident's susceptibility to abuse by another individual, including other vulnerable adults. b. The residents' risk of abusing other vulnerable adults. c. Specific measures to be taken to minimize the risk of abuse to the residents and to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650			

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0 650	Continued From page 13 services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on June 8, 2026, to provide direct care and services to residents. ULP-B ULP-B was hired on January 13, 2025, to provide direct care and services to residents. ULP-A and ULP-B's employee record lacked documentation for the following training: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive,	0 650			

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0 650	Continued From page 14 and developmental needs of the resident. On August 20, 2026, at 10:30 a.m., licensed assisted living director (LALD)-D stated the above-mentioned training was given to the employees, but they did not have documentation for any of the employees. On August 20, 2026, at 10:48 a.m., ULP-B stated they think they did receive the above-mentioned training. On August 20, 2026, at 11:40 a.m. ULP-A stated they had received the training mentioned above. The licensee's 5.02 Employee Records and Background Studies policy dated May 31, 2024, indicated documentation of required orientation, annual training, infection control training, competency evaluations, and required supervision will be maintained in the personnel record. Training documentation will identify sufficient information to demonstrate completion, including the training completed and date of completion. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060			

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01060	Continued From page 15 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060			

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01060	Continued From page 16 licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 was admitted to the licensee on June 20, 2025, with diagnoses that included nontraumatic intracerebral hemorrhage and type 2 diabetes mellitus. R4's unsigned Master Care Plan updated on August 18, 2026, indicated R4 received services for toileting, grooming, bathing, dressing, ambulation, transfer, and medication administration. R4's resident record included Resident Notes -Nurse written on August 19, 2026, at 12:32 p.m., which indicated R4 was admitted to the hospital on July 15, 2026, and transferred to transitional care unit on July 28, 2026, for unknown duration of time. R4 was out of the licensee's facility during the survey. R4's record lacked evidence, a written notice was provided that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated	01060			

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01060	Continued From page 17 and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal; and - a notice to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On August 20, 2026, at 10:55 a.m., clinical nurse supervisor (CNS)-C stated they did not provide the emergency relocation form to R4. CNS-C also stated they had not notified the ombudsman about R4's relocation. CNS-C stated they were not aware of the requirement to provide a written notice with required contents for an emergency relocation or the requirement to notify ombudsman if a resident stayed out of the facility for more than four days. CNS-C stated their understanding was that they notify the ombudsman if there is serious injury. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=D	144G.60 Subdivision 1 Background studies required	01290			

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01290	Continued From page 18 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received an affiliation with the assisted living license for four of 23 employees (unlicensed personnel (ULP)-G, ULP-H, ULP-J, ULP-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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: ULP-G was hired on October 13, 2025, to provide assisted living services.	01290			

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01290	Continued From page 19 R1's Medication Administration Summary for the month of August 2026, indicated ULP-G administered morning medication to R1 on August 18, 2026. ULP-H was hired on February 2, 2026, to provide assisted living services. R1's Medication Administration Summary for the month of August 2026, indicated ULP-H administered morning medication to R1 on August 1, 2026. ULP-J was hired on January 19, 2026, to provide assisted living services. R1's Medication Administration Summary for the month of August 2026, indicated ULP-J administered evening medication to R1 on August 2, 2026. ULP-K was hired on April 28, 2026, to provide assisted living services. R1's Service Recap Summary for the month of August 2026, indicated ULP-K assisted R1 with activities of daily living (transfer assist, grooming, toileting, and skin assessment), the morning of August 1, 2026. The licensee's NetStudy 2.0 roster (web-based system for submitting background study requests to the Department of Human Services) for their health facility identification number (HFID) 33870 did not include ULP-G, ULP-H, ULP-J, or ULP-K in the list of employees whose BGS were affiliated with HFID 33870. The licensee's sister facility's roster, HFID 34321, included all of the above-mentioned employees. On August 17, 2026, at 11:17 a.m., via email correspondence, director of operations (DO)-E provided the surveyor a 14-page long employee	01290			

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01290	Continued From page 20 roster entitled Employee Hire Report, Company: Multiple Facility dated january1, 2018 through August 22, 2026. On August 17, 2026, at 11:25 a.m., DO-E stated all employees were cross trained to work at all of the licensee's facilities. DO-E stated employees were not hired for a specific facility rather they hired employees to work at all. On August 18, 2026, at 8:14 a.m., via email correspondence, collections and case management specialist (CCMS)-L provided the surveyor with Employee List specific to HFID 33870 which contained a list of 23 employees. On August 18, 2026, at 9:45 a.m., licensed assisted living director (LALD)-D stated all employees should have been affiliated with the licensee's HFID and they did not know why they are not affiliated. LALD-D stated the Department of Human Services did not make affiliation easy. The licensee's 5.02 Employee Records and Background Studies policy dated May 31, 2024, indicated background studies will be conducted as required for employees, contractors, and regularly scheduled volunteers of the assisted living facility. The licensee will also ensure that license applicants, owners, managerial officials, and controlling individuals complete background studies when required by Minnesota law. The licensee will follow the applicable statutory exception for an individual who holds a valid license issued by a Minnesota health-related licensing board and has completed the criminal background check required by Minnesota Statutes § 214.075. When that exception applies, the individual will be handled in NETStudy 2.0 as required by § 144.057.	01290			

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01290	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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: On August 20, 2026, at approximately 10:35 p.m., the surveyor observed the following expired medication for R3: -senna-Time S tablet 8.6-50mg, expired on April 22, 2026; and -Methocarbamol 500mg tablet, half tablets expired on April 22, 2026.	01880			

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01880	Continued From page 22 On August 20, 2026, at 1:25 p.m., clinical nurse supervisor (CNS)-C stated a pharmacist audited the medication room on August 4, 2026, and they did not know why the expired medication was not caught during the audit. The licensee's 7.11 Medication Storage Policy dated June 17, 2024, indicated medication storage areas will be routinely monitored for security, cleanliness, medication integrity, appropriate storage conditions, expired or discontinued medications, and evidence of diversion or discrepancies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02310 SS=I	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 observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for four of four residents (R1, R2, R3, R4) with hospital-style and/or consumer bed rails. This resulted in an immediate correction order on August 19, 2026.	02310			

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02310	Continued From page 23 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 18, 2026, at approximately 12:30 p.m., during a facility tour, the surveyor observed bed rails attached to R1, R2, R3, and R4's bed. R1 R1 was admitted to the licensee on February 17, 2025, with diagnoses that included down syndrome. R1's signed Service Plan dated April 7, 2025, indicated R1 received services for bathing, dressing, grooming, medication administration, meal assistance, and housekeeping. On August 17, 2026, at approximately 12:35 p.m., during a facility tour, the surveyor observed an upper half hospital-style bed rail attached to the right side of R1's electric bed. R1's Clinical Update Assessment completed on August 10, 2026, indicated the following under the Safety section of the assessment: - bed type- electric bed; - mattress type: mattress original to bed; and - entrapment zone 1 measurement. R1's bed rail assessment lacked the following required information:	02310			

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02310	Continued From page 24 - purpose and intention of the bed rail; - the resident's bed rail use/need assessment; - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - assessment that the bed rail has not shifted and is securely attached to the bed frame per manufacturer's recommendations; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements, and - entrapment zone measurements for zones 2 through 7 to demonstrate bed rail meets food and drug administration (FDA) guidelines. R1's Bed Safety Assessment completed on August 18, 2026, (during the survey) indicated the following information: - bed type- electric bed; - mattress type: mattress original to bed; - bed rail meets food and drug administration (FDA) guidelines; and - entrapment zone measurements for zones 2 through 7. R2 R2 was admitted to the licensee on September 25, 2024, with diagnoses that included type 2 diabetes mellitus. R2's unsigned Master Care Plan updated on August 17, 2026, indicated R2 received services for bathing, dressing, ambulation, transfer, medication administration, and meal assistance. On August 18, 2026, at approximately 2:10 p.m., the surveyor observed a consumer bed rail attached to the upper left side of R2's electric bed. The surveyor also observed a red bungee	02310			

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NAME OF PROVIDER OR SUPPLIER THE GENEVA SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 PARKWOOD ROAD EDINA, MN 55436		
(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
02310	Continued From page 25 cord wrapped around and hooked to the bottom of the consumer bed rail along with an electrical cord. The bed rail was wrapped with a white grip-style tape, which had come loose and unwound at the ends. In addition, the right side of the bed had an upper half hospital-style bed rail attached. R2's record included a Clinical Updated Assessment completed on May 19, 2026. The assessment included the following information under Safety section of the assessment: - bed type- roll away bed; - mattress type- mattress original to bed; - bed rails in use, include description and condition of bed rail: purchased privately; - describe rationale for bed rails (include medical condition / symptoms, resident preference) specify- uses these for repositioning, turning side to side and sitting up; - bed rails are appropriate based upon assessed need: yes can safely use bed rails; - bed safety zones (Hospital Bed System ONLY)- the bed rail meets FDA guidelines; - do the bed rails function as a restraint: No; - is the resident at high risk for injury if bed rails are in use (cognition): No; - has the resident had a previous injury related to bed rails: No; - if bed rails are in use, has education been provided to the resident / responsible party of the risks and benefits of the bed rails and was understanding verbalized: yes, resident verbalizes understanding of benefits and risks for bed rails. R2's bed rail assessment lacked the following required information: - entrapment zone measurements; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct	02310			

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02310	Continued From page 26 installation per the manufacture's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - the assessment did not mention a consumer bed rail. R2's resident record included a Bed Safety Assessment completed on August 17, 2026, (during the survey) with the required information for the hospital-style bed rail. The bed safety assessment did not mention R2's consumer bed rail. R2's record lacked an assessment for consumer bed rails to be completed upon installation, every 90 days, and with change of conditions to assess: - purpose and intention of the bed rail; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment; - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and - documentation that the Consumer Product Safety Commission (CSPC) was checked regularly or with every 90 day assessment for product recalls. R3 R3 was admitted to the licensee on August 4, 2025, with diagnoses that included dementia and hypothyroidism.	02310			

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02310	Continued From page 27 R3's unsigned Master Care Plan updated on August 17, 2026, indicated R3 received services for toileting, grooming, bathing, dressing, ambulation, transfer, medication administration, and meal assistance. On August 17, 2026, at approximately 12:35 p.m., during a facility tour, the surveyor observed bilateral upper half hospital-style bed rails attached to both sides of R3's hospital-style electric bed. R3's Clinical Update Assessment completed on August 10, 2026, indicated the following under the Safety section of the assessment: - bed type- electric bed; - mattress type: mattress original to bed; - bed rails in use include description and condition of bed rails: secure and stable; - bed rails are appropriate based upon assessed need and resident preference: yes; and - bed safety zones: the bed rail meets FDA guidelines. R3's bed rail assessment lacked the following required information: - purpose and intention of the bed rail; - the resident's bed rail use/need assessment; - entrapment zone measurements; - assessment that the bed rail has not shifted and is securely attached to the bed frame per manufacturer's recommendations; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R3's resident record also included a Bed Safety Assessment completed on August 17, 2026, (during the survey) and indicated the following	02310			

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02310	Continued From page 28 information: - bed type- electric bed; - mattress type: mattress original to bed; - bed rails in use include description and condition of bed rails: secure and stable; - bed rails are appropriate based upon assessed need and resident preference: yes - bed rail meets food and drug administration (FDA) guidelines; and - entrapment zone measurement for zones 1 through 7. R4 R4 was admitted to the licensee on June 20, 2025, with diagnoses that included nontraumatic intracerebral hemorrhage and type 2 diabetes mellitus. R4's resident record included Resident Notes -Nurse written on August 19, 2026, at 12:32 p.m., (during the survey) which indicated R4 was admitted to the hospital on July 15, 2026, for a urinary tract infection and was transferred to a transitional care unit on July 28, 2026, for an unknown duration of time. R4 remained out of the licensee's facility during the survey. R4's unsigned Master Care Plan updated on August 18, 2026, (during the survey) indicated R4 received services for toileting, grooming, bathing, dressing, ambulation, transfer, and medication administration. On August 17, 2026, at approximately 12:35 p.m., during a facility tour, the surveyor observed bilateral upper half hospital-style bed rails attached to both sides of R4's electric bed. R4's resident record included Clinical Update Assessment completed on June 1, 2026, and	02310			

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02310	Continued From page 29 indicated the following information under the Safety section of the assessment: - bed type- electric bed; - mattress type: mattress original to bed; - bed rails in use include description and condition of bed rails : half bed rails in use to assist resident in bed mobility, (did not indicate the condition of the bed rail); - bed rails are appropriate based upon assessed need and resident preference: yes; - bed safety zones: the bed rail meets FDA guidelines; - do the bed rails function as a restraint: No; - is there a high risk for injury if bed rails are in use (cognition): No; - is there a history of injury related to bed rails: No - are there any medications prescribed that could affect mental status and increase the risk for injury with the use of bed rails: No; - are there alternatives to bed rails if in use: No; - if bed rails are in use, has education been provided to the resident and/or responsible party of the risks and benefits of the bed rails and was understanding verbalized: Yes, specify: staff educated on bed rails. R4's assessment lacked entrapment zone measurements and documentation that the bed rail was installed and maintained per the manufacture's guidelines. In addition, R4's resident record included a Bed Safety Assessment completed on August 18, 2026, (during the survey) and while R4 was still out of the facility. On August 17, 2026, at 2:20 p.m., clinical nurse supervisor (CNS)-C stated they did not know what kind of a consumer bed rail was attached to R2's bed and they did not have the name, model number, or the manufacturers guidelines.	02310			

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02310	Continued From page 30 On August 17, 2026, at 2:25 p.m., licensed assisted living director (LALD)-D stated they used the FDA guidelines as a manufacturer guideline for all the bed rails. On August 17, 2026, at approximately 2:30 p.m., CNS-C stated there was no identifying information on R2's bed rail and R2 did not have the bed rail information either. CNS-C stated that R2 knew the bed rail was out of compliance but R2 wanted it, and it was R2's preference to have the consumer bed rail. LALD-D stated they knew it was not a typical bed rail and they had explained it to R2, but that was what R2 wanted, and stated it was R2's preference. On August 18, 2026, at 1:23 p.m., CNS-C stated they were aware of the required contents for a bed rail assessment and the questions were all included in Residex (electronic medical record software) but they did not answer all of the questions. CNS-C also stated they re-assessed every 90 days and as needed with change of condition, they stated they had done the assessment for R1 but they did not chart it. CNS-C also stated they did not answer all of the questions because they did not think it was mandated by the state to have all of the questions in the Residex assessment answered. On August 18, 2026, at 2:16 p.m., CNS-C stated R3 got a new bed yesterday, and that was why the bed rail assessment was completed on August 18, 2026. The surveyor asked CNS-C about R3's bed safety zone measurement that was indicated on the assessment completed on August 10, 2026, where it said the bed rail meets the FDA guidelines and there were no measurements charted. CNS-C stated if it said it	02310			

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02310	Continued From page 31 meets the FDA guidelines then it was measured, but the measurements were not documented. On August 18, 2026, at 3:05 p.m., R2 stated they had a hospital bed rail attached to the bed before the consumer bed rail was attached to the bed. R2 stated the previous bed rail was blocking the way and R2 stated that they get up to use the bathroom frequently so they switched to the consumer bed rail and it was working for them. On August 18, 2026, at 3:20 p.m., the surveyor asked R2 if they were offered another bed rail by the licensee. R2 stated no another bed rail was offered, they had the consumer bed rail they are using for a long time and when the hospital bed rail did not work for them, they switched it to the consumer bed rail they already had. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." Additionally, the FAQ indicated documentation of a hospital-style bed rail should include but is not limited to: - purpose and intention of the bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks);	02310			

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02310	Continued From page 32 - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The FAQ also listed the following required information to be included in resident's assessment for consumer bed rails: - purpose and intention of the bed rail; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks) - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and - licensees should review the CSPC website regularly for updates on recalled portable bed rails. The licensee's Bed Rails Usage policy dated July 11, 2021, indicated before a new bed rail or bed assist device is placed into use, a registered nurse must complete and document an individualized assessment. The assessment will include, as applicable: " the specific purpose and intended benefit of the device; " the resident's physical condition and mobility;	02310			

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02310	Continued From page 33 " ability to independently reposition in bed; " ability to transfer into and out of bed; " balance and fall history; " cognition, judgment, confusion, impulsivity, and ability to understand the purpose of the device; " restlessness or uncontrolled body movements; " pain or other conditions affecting movement; " continence and toileting needs; " ability to summon assistance; " likelihood that the resident may attempt to climb over, around, under, or between the rail; " risk of entrapment between the rail, mattress, headboard, footboard, or bed frame; " whether the device could restrict the resident's freedom of movement; " compatibility of the rail with the mattress and bed; " manufacturer specifications, contraindications, height and weight restrictions, and installation requirements; " alternative interventions considered; and " the resident's preferences and goals. o The RN must determine whether the expected benefit of the device outweighs the individualized risks to the resident. Bed rails and bed assist devices must be installed, used, and maintained according to the manufacturer's instructions and intended use. The Geneva Suites will maintain or have reasonable access to the manufacturer's installation and use instructions for each bed rail in use. Before use, the RN or other appropriately qualified individual designated by the RN will verify: " manufacturer and model, when identifiable; " compatibility with the bed and mattress; " correct installation;	02310			

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02310	Continued From page 34 " secure attachment; " appropriate positioning; " condition of the device; " absence of loose, broken, damaged, or missing components; and " potential spaces where the resident's head, neck, chest, limbs, or body could become entrapped. For hospital-style beds and rails, required measurements and entrapment-risk evaluation will be completed and documented consistent with accepted FDA bed safety guidance. A device that cannot be securely installed or used according to manufacturer recommendations will not be placed into service until the safety concern has been resolved. Family, hospice, therapy or outside-provider equipment - Residents, family members, hospice agencies, durable medical equipment providers, therapists, or other outside providers may not place a bed rail or new bed system into use without notifying The Geneva Suites. The Geneva Suites remains responsible for evaluating the safety and appropriateness of bed rails used by residents receiving assisted living services. When staff discover a new or changed bed rail that has not been assessed, staff must notify the RN promptly. The device will not routinely be used until the RN has evaluated its safety and appropriateness. Delivery of a hospital bed by hospice or another provider does not replace The Geneva Suites' responsibility to assess the resident's use of the bed rails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			

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02320	Continued From page 35	02320			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP)-A, ULP-B) followed appropriate transfer and transport procedures. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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: ULP-A ULP-A was hired on June 8, 2026, to provide assisted living services. ULP-A's personnel file included a Competency Tracking Form dated June 11, 2026, which indicated the following: - ULP-A was found competent to use commonly used assistive devices; - ULP-A was found competent to use mechanical	02320			

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02320	Continued From page 36 lifts; and - ULP-A was found competent on transfer and ambulation techniques. ULP-B ULP-B was hired on January 13, 2025, to provide assisted living services. ULP-B's personnel file included a Competency Tracking Form dated January 14, 2025, which indicated the following: - ULP-B was found competent to use commonly used assistive devices; - ULP-B was found competent to use mechanical lifts; and - ULP-B was found competent on transfer and ambulation techniques. On August 19, 2026, at 11:58 a.m., the surveyors observed ULP-A and ULP-B transfer R3 using a gait belt from a lifting recliner in the living room to a sit-to-stand style mechanical lift. The surveyor asked if this process always involved two staff members. One ULP said, "not all the time but that's how we were instructed". The ULPs then escorted R3, still in the lift, using the lift as a mobility device, from the living room, through the corner of the kitchen, through the dining room, and down a hallway to reach the resident's room to take the resident to the bathroom. On August 19, 2026, at approximately 2:40 p.m., clinical nurse supervisor (CNS)-C stated the sit-to-stand style mechanical lift they used to transfer R3 was called "Sara Stedy" which was the brand of the lift. The surveyor explained to CNS-C their observation from earlier and asked if the lift should be utilized for longer distance mobility. CNS-C stated "No". CNS-C stated they would never have allowed that to occur if they	02320			

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02320	Continued From page 37 had witnessed it and would have intervened immediately. CNS-C stated that they held an in-service with the staff after R3's daughter provided the lift, and that was not how the staff were trained. CNS-C stated all staff would need to be re-trained. When the surveyor asked what the risks were in transporting a resident by using the lift, CNS-C stated "death". CNS-C also stated risk of injury to R3, and risk of injury to another resident. On August 20, 2026, at 11:13 a.m., CNS-C provided the surveyor with a manual titled Instruction for Use Sara Stedy, Sara Stedy Compact. The instruction indicated the following items for Sara Stedy's intended use: - Sara Stedy is a mobile active lift with a safe working load of 182 kilogram (KG) (400 pound (lb). It is intended to assist caregivers in hospitals, long term care, nursing homes and homecare environments, including private homes. - warning: to avoid injury, transfers must only be performed on flat, non-sloping surfaces/ floors to prevent the Sara Stedy from tipping over; - Sara Stedy is manufactured to a very high standard and has been designated to quickly and easily transport or transfer patients from one sitting to another. It is not intended for long periods of sitting or transfer; - Sara Stedy is intended to transfer a patient to/from a chair, wheelchair, a bed and a toilet; - Sara Stedy may also be used as supportive aid when elevating a patient for the purpose of changing wound dressings, incontinence pads or for personal cleaning; - Sara Stedy is also suitable for rehabilitation exercise; - any reference to the "patient" in this document apply equally to a resident at home or in a long term care facility and refer to the person	02320			

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NAME OF PROVIDER OR SUPPLIER THE GENEVA SUITES		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 PARKWOOD ROAD EDINA, MN 55436			
(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
02320	Continued From page 38 transferred; - Sara Stedy must be used by appropriately trained caregivers with adequate knowledge of the care environment, its common practices and procedures, and in accordance with guidelines in the instruction for use; and - Sara Stedy should only be used for the purpose specified in this instructions for use. Any other use is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

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Establishment Info

THE GENEVA SUITES
6200 PARKWOOD ROAD
Edina, MN 55436
Hennepin County
Parcel:

Phone:

License Info

License: HFID 33870

Risk:
License:
Expires on:
CFPM: Marlena Hemenway
CFPM #: 34104; Exp: 3/29/2023

Inspection Info

Report Number: F7994261179
Inspection Type: Full - Single
Date: 8/17/2026 Time: 12:32:55 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12DMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: CFPM was not posted on site. CFPM was emailed during inspection.

Comply By: 8/17/2026 Originally Issued On: 8/17/2026

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, GRANITE COUNTER TOPS AND PAINTED TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

TEMPERATURES:

Fruit 40
Sauce 40

HRD INSPECTOR: Dee Mosissa

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F7994261179 from 8/17/2026

Ranya Abuied

Crystal Elva, REHS, MS, BS

Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version EH Manager; RPT: F7994261179			Food Establishment Inspection Report			Page 1 of 1			
 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164			No. of Risk Factor/Intervention/Violations		1	Date: 8/17/2026			
			No. of Repeat Risk Factor/Intervention/Violations			Time: 12:32:55 PM			
			Score (optional)			Dur: min			
Establishment: THE GENEVA SUITES		Address: 6200 PARKWOOD ROAD		City/State: Edina, MN		Zip: 55436		Phone:	
License/Permit #: HFID 33870		Permit Holder:		Purpose of Inspection: Full		Est. Type:		Risk Category:	
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS									
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation				
Compliance Status			COS	R	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	OUT	Certified Food Protection Manager			19	N/A	Proper reheating procedures for hot holding		
Employee Health					20	N/A	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	N/A	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	IN	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	N/A	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	IN	Hands clean and properly washed			26	N/A	Pasteurized foods used; prohibited foods not offered		
9	IN	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	IN	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	IN	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	IN	Food separated and protected							
16	IN	Food-contact surfaces; cleaned & sanitized							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							
GOOD RETAIL PRACTICES									
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" or OUT in box if numbered item is not in compliance			Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation						
			COS	R				COS	R
Safe Food and Water					Proper Use of Utensils				
30	N/A	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/A	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48		Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
					58		Compliance with licensing and plan review		
Inspector (signature)					Follow-up: Follow-up Date:				