Electronically Delivered

February 14, 2025

Licensee
The Geneva Suites
6222 Braeburn Circle
Edina, MN 55439

RE: Project Number(s) SL33436016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 12, 2024, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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.

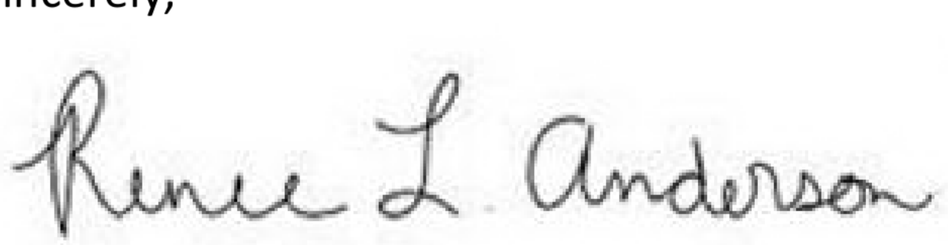
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,



Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33436	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6222 BRAEBURN CIRCLE EDINA, MN 55439

(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 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: SL33436016 On December 9, 2024, through December 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license.	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 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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for one of two staff (unlicensed personnel (ULP)-F). 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 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-F was hired on October 12, 2020, and provided direct cares to residents. On December 9, 2024, at 11:25 a.m., ULP-F was observed to assist R2 with personal cares in R2's	0 510		

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0 510	Continued From page 2 bedroom. ULP-F was wearing gloves and stated she had already performed HH. With gloved hands, ULP-F assisted R2 to get dressed, and placed an ankle-foot orthosis (AFO) on his left leg. Next, ULP-F grabbed two partially filled urinals from R2's bedside table and emptied them in the toilet. Without changing gloves or performing HH, ULP-F next assisted R2 with to wipe his face and mouth area with a washcloth. ULP-F then removed the soiled gloves and, without performing HH, donned a new pair of gloves. ULP-F then retrieved R2's toothbrush, assisted R2 with oral cares, and applied R2's underarm deodorant. Next, ULP-F wheeled R2 in his wheelchair, to the kitchen area to have breakfast. While in the kitchen area, ULP-F touched the kitchen counter with her donned gloves. ULP-F then removed the gloves and, without performing HH, proceeded into the medication storage room. On December 9, 2024, at 11:55 a.m., ULP-F stated she received training on infection control upon hire and at other meetings with the nurse. ULP-F verbalized she was nervous being observed, so must have missed completing HH as she was trained to do. On December 9, 2024, at 12:30 p.m., licensed practical nurse (LPN)-D stated all employees were trained upon hire, annually, and if a nurse observed an infection control concern. LPN-D verbalized she planned to follow up with additional education for all the employees. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated, standard precautions were to be used to care for all	0 510		

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0 510	Continued From page 3 patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient; b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c. Before moving from work on a soiled body site to a clean body site on the same patient; d. After touching a patient or the patient's immediate environment; e. After contact with blood, body fluids or contaminated surfaces; and f. Immediately after glove removal." The licensee's 8.09 Hand washing policy, dated June 17, 2024, indicated "Proper hand washing techniques should be used to protect against the spread of infection. Hand washing shall be completed: -Before, during, and after preparing food -Before eating food -Before and after caring for someone who is sick -Before and after treating a cut or wound -After using the toilet -After changing diapers or cleaning up after someone who has used the toilet -After blowing your nose, coughing, or sneezing -After touching an animal or animal waste -After handling pet food or pet treats -After touching garbage." The licensee's Glove Use policy dated June 17, 2024, indicated " 1. When to Wear Gloves. Care Partners are required to wear gloves in the following situations: -When providing personal care that involves contact with bodily fluids (e.g., blood, saliva, urine, feces).	0 510		

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0 510	Continued From page 4 -During wound care or dressing changes. -When handling soiled laundry or waste. -During meal preparation. -When cleaning or disinfecting surfaces, equipment, or other high-touch areas. 2. Proper Glove Use -Wash or sanitize hands before donning gloves. -Inspect gloves for tears or defects before use. -Use gloves only for the specific task at hand. -Avoid touching unnecessary surfaces while wearing gloves. -Discard gloves immediately after use. -Wash or sanitize hands immediately after removing gloves." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of	0 550		

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0 550	Continued From page 5 Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, including the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents. 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 the potential to affect a large portion or all of the residents). The findings include: On December 9, 2024, at 10:40 a.m., the surveyor observed the common area in the main entry of the facility where the postings were located. The licensee lacked a posted grievance procedure with the name, telephone number and email contact information for the individual who was responsible for handling resident grievances. On December 9, 2024, at 10:50 a.m., the director of operations (DO)-C stated the complaint posting was not updated with the current facility contact information, and he planned to get the contact information updated and the procedure posted. The licensee's Complaint/Grievance Posting policy, effective August 6, 2024, indicated, "a. The [Licensee] will post, in a conspicuous place,	0 550		

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0 550	Continued From page 6 information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included	0 660		

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0 660	Continued From page 7 baseline testing for one of three employees (unlicensed personnel (ULP)-F). 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 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 December 9, 2024, at 11:18 a.m., the surveyor observed ULP-F administer medications to R2. ULP-F was hired on October 12, 2020, and provided direct cares to licensee residents. ULP-F's employee record included a TB symptom screening form dated September 29, 2020, indicating no previous adverse reaction to a tuberculin skin test (TST) and consent to a TB blood test. The record included a normal chest x-ray result dated December 9, 2019. ULP-F's record lacked documentation of a previous positive TB skin test correlated to the chest x-ray, or documentation of a TB blood test or TST completed within 90 days prior to hire. On December 9, 2024, at 10:43 a.m., and December 12, 2024, at 1:00 p.m., the surveyor requested, via email, a copy of the licensee's TB prevention and screening policy. The policy was not provided. On December 12, 2024, at 1:00 p.m., the director of operations (DO)-C stated the licensee was	0 660		

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0 660	Continued From page 8 unable to find a documented positive TB test or chest x-ray information for ULP-F. In addition, DO-C verbalized the licensee ordered a new TB testing and screening to be completed for ULP-F. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, HCW with a verbal (undocumented) history of a previous positive TST or IGRA. These HCW's should undergo the same screening procedures as HCW's without previous positive results. Results of the screening should be documented in the HCW's record. If the HCW has documentation of previous treatment for latent TB infection or active TB disease, that documentation may be substituted for documentation of previous positive TST or IGRA results. No further information was provided.	0 660		

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0 660	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.	0 780		

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0 780	Continued From page 10 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: On December 11, 2024, at 9:45 a.m., survey staff toured the facility with director of operations (DO)-C. DO-C tested the smoke alarms throughout the home. Upon testing, the smoke alarms it was found that the basement smoke alarm was not interconnected with the smoke alarms on the main floor. These deficient conditions were visually verified by DO-C accompanying on the tour and he stated that he understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 11 (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan (FSEP) with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. 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	0 810		

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(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
0 810	Continued From page 12 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: On December 12, 2024, at 10:15 a.m., director of operations (DO)-C provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) was very basic. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log indicated evacuation drills were conducted on October 2, 2024, and November 25, 2024. No other documentation was provided. DO-C stated that they were doing the evacuation drills quarterly and he understood the requirements for employees twice per year, per shift with at least one evacuation drill every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01290	Continued From page 13	01290		
01290 SS=D	144G.60 Subdivision 1 Background studies required (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 observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of three employees (unlicensed personnel (ULP)-F). 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:	01290		

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01290	Continued From page 14 ULP-F was hired on October 12, 2020, and provided direct care services to residents. On December 9, 2024, at 11:18 a.m., the surveyor observed ULP-F assist R2 with medication administration. ULP-F's employee record contained a Department of Human Services (DHS) background study clearance form dated October 6, 2020. The background study had been submitted through a separate location, health facility identification (HFID) 32475, also operated by the licensee's owner; however, ULP-F's employee record lacked evidence the licensee ensured a cleared background study was obtained, affiliated with the surveyed assisted living license, HFID 33436. On December 10, 2024, at 1:58 p.m., the director of operations (DO)-C provided, via email, an updated DHS background study clearance form, affiliated with the licensee HFID 33436, dated December 9, 2024, during the survey. On December 12, 2024, at 1:00 p.m., DO-C stated ULP-F worked at other facilities the licensee owned and stated, ULP-F's background study dated October 6, 2020, was the only clearance the licensee obtained, until the survey was in process. DO-C stated he did not realize ULP-F's background study was not affiliated with the licensee until the surveyor requested it. The licensee's 4.02 Background Studies policy, dated June 17, 2024, indicated, "[Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Licensee]. No	01290		

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01290	Continued From page 15 employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. [Licensee] will not employ individuals whose results of the background study indicate disqualification for the position. The policy lacked direction that the background study must be affiliated with the licensee, as required." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

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01470	Continued From page 16 (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees completed orientation including all required	01470		

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01470	Continued From page 17 content, prior to providing assisted living services, for one of three employees (unlicensed personnel (ULP)-F). 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 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-F was hired on October 12, 2020, and provided direct cares to residents. On December 9, 2024, at 11:25 a.m., the surveyor observed ULP-F assist R2 with medication administration. ULP-F's employee record lacked documentation the following orientation topics were completed: -Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659; -Review of the types of assisted living services the employee will provide, and the provider's scope of license; and -The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. On December 11, 2024, at 9:40 a.m., director of operations (DO)-C stated the licensee's training program included online, in-person, and shadowing another caregiver. DO-C verbalized ULP-F missed completing some of the required training content.	01470		

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01470	Continued From page 18 On December 12, 2024, at 1:00 p.m., DO-C stated the licensee planned to send ULP-F through the licensee's orientation program again. The licensee's 5.01 Orientation of Staff and Supervisors & Content and policy, dated May 31, 2024, indicated, "All staff of [Licensee] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	01500		

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01500	Continued From page 19 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees	01500		

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01500	Continued From page 20 received at least eight (8) hours of annual training including required content, for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-F). 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 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-F was hired on October 12, 2020, and provided direct cares for residents. On December 9, 2024, at 11:25 a.m., the surveyor observed ULP-F administer medications to R2. ULP-F's employee record indicated annual training was completed in June 2024. ULP-F's employee record lacked documentation of the number of hours of annual training completed within the last 12 months, and lacked documentation the following required topics were completed: -training on reporting of maltreatment of vulnerable adults under section 626.557; and -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. On December 11, 2024, at 9:40 a.m., director of operations (DO)-C stated the licensee's annual training included online, and in-person training. DO-C verbalized ULP-F missed completing some	01500		

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01500	Continued From page 21 of the required annual training content. On December 12, 2024, at 1:00 p.m., DO-C stated the licensee planned to send ULP-F through the licensee's orientation program again. The licensee's 5.06 Annual Required Staff Training policy dated May 31, 2024, indicated, "All staff that perform direct care services at [Licensee] will complete at least eight (8) hours of annual training for each 12 months of employment. Also, included "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and	01500		

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01500	Continued From page 22 service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained, including the opened date for time sensitive medication storage for one of two residents (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) 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: R3 was admitted on June 19, 2020, and had diagnoses including quadriplegia (paralysis that	01890		

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01890	Continued From page 23 affects all a person's limbs), and type two diabetes (the body is unable to keep blood sugar at normal levels). R3's Service Plan dated March 5, 2020, indicated R3 received services including assistance with housekeeping, laundry, bathing, dressing, grooming, toileting, mobility, blood glucose monitoring, and medication management. On December 10, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-G administer insulin and other medications to R3. R3's medication administration record (MAR) for December 2024, indicated R3 was administered Humalog insulin pen (fast-acting insulin) daily from December 1, through December 10, 2024. On December 10, 2024, at 8:40 a.m., the surveyor observed R3's medication storage contained one opened Humalog insulin pen dated November 10, 2024, two days beyond the 28 day expiration per manufacturer's directions. The medication storage also contained one opened Lantus (long-acting insulin) insulin pen. The Lantus pen lacked a label to indicate the date staff first used the insulin and when the insulin would expire. ULP-G stated the staff were trained to date the insulin pen when it was first opened, but this one must have been missed. On December 10, 2024, at 11:25 a.m., clinical nursing supervisor (CNS)-B and licensed practical nurse (LPN)-D stated the caregivers were trained to date insulin pens when they were opened. The manufacturer's instructions for the use of the Humalog insulin pen revised March 2013,	01890		

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01890	Continued From page 24 indicated the opened Humalog insulin pen would be stored at room temperature only, and once opened, should be discarded after 28 days. The manufacturer's instructions for the use of the Lantus insulin pen revised May 2019, indicated the opened Lantus insulin pen would be stored at room temperature only, and once opened, should be discarded after 28 days. The licensee's 7.11 Medication Storage policy dated June 17, 2024, indicated "When medications are managed and stored by [Licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions	01940		

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01940	Continued From page 25 relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two 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) 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: R3 had diagnoses including quadriplegia (paralysis that affects all the limbs), and type two diabetes (the body is unable to keep blood sugar	01940		

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01940	Continued From page 26 at normal levels). R3's Service Plan dated March 5, 2020, indicated R3 received services including assistance with housekeeping, laundry, bathing, dressing, grooming, toileting, mobility, and medication management. The service plan lacked any indication the licensee assisted R3 with blood glucose monitoring. On December 10, 2024, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-G assist R3 with medication administration and blood glucose monitoring. R3's medical record included an Assessment dated October 22, 2024, which indicated R3 needed assistance with blood sugar checks. The assessment further indicated R3 used a Freestyle Libre sensor (a sensor attached to the upper arm that continuously transmits blood glucose readings), which the nurse was to apply every 14 days and as needed. The assessment also indicated R3 would require traditional blood glucose testing when the Freestyle Libre was not working properly. R3's record lacked a treatment and therapy management plan for R3's blood glucose testing with the following required content: -identification of treatment or therapy tasks that would be delegated to unlicensed personnel; -procedures for notifying a RN or appropriate licensed health professional when a problem arose with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification all treatment and therapy were administered as prescribed, and monitoring of treatment or therapy to prevent possible	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33436	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6222 BRAEBURN CIRCLE EDINA, MN 55439

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01940	Continued From page 27 complications or adverse reactions. On December 11, 2024, at 1:23 p.m., clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-D stated it appeared R3's assessment did not include a treatment management plan with all the required content. CNS-B verbalized she was new to her position training with LPN-D this week but would review the treatment plan required content and planned to have this updated for R3. The licensee's policy regarding development of the treatment management plan was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01960		

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01960	Continued From page 28 review, the licensee failed to document treatment administration, or indication why the treatment was not administered as ordered, for one of one resident (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: R3 had diagnoses including quadriplegia (paralysis that affects all a person's limbs), and type two diabetes (the body is unable to keep blood sugar at normal levels). R3's Service Plan dated March 5, 2020, indicated R3 received services including assistance with housekeeping, laundry, bathing, dressing, grooming, toileting, mobility, and medication management. The service plan lacked any indication the licensee assisted R3 with blood glucose monitoring. On December 10, 2024, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-G assist R3 with medication administration and blood glucose monitoring. R3's medical record included an Assessment dated October 22, 2024, which indicated R3 needed assistance with blood sugar checks. The assessment indicated R3 used the Freestyle Libre sensor (a sensor affixed to the upper arm	01960		

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01960	Continued From page 29 that provides access to continuous blood glucose readings), which the nurse would re-apply every 14 days and as needed. The assessment indicated R3 needed blood glucose testing when the Freestyle Libre was not working properly. R3's medical record included an electronically transmitted prescription dated July 10, 2024, with directions to test three times daily before meals for continuous blood glucose monitoring using the Freestyle Libre 14-day Sensor. R3's medical record included an electronically transmitted prescription dated September 26, 2024, with directions to check blood sugars when the continuous glucose monitoring was not working. R3's Service Recap Summary for December 1, 2024, through December 9, 2024 (printed December 10, 2024), indicated R3 was scheduled to have blood glucose levels recorded twice daily at 7:00 a.m., and 3:00 p.m. The Service Recap Summary indicated R3's blood glucose level was not recorded at 3:00 p.m., on December 1, 4-5, 7, and 9. There was no documented refusal or indication as to why the service was not provided. The scheduled services did not indicate blood glucose levels be recorded three times per day, as ordered. R3's record included documentation of blood glucose levels from November 10, 2024, through December 9, 2024 (printed December 10, 2024). The documentation indicated blood glucose levels were recorded only once daily on November 11, 13-14, 19, 21-22, 25-26, and December 1, 4-5, 7, 9. The documentation indicated blood glucose levels were recorded only twice daily on November 10, 12, 15-18, 20, 23-24,	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 30 27-29, 30, 2024, and December 2-3, 6, and 8. The documentation only indicated "AM" or "PM", lacking the time of the monitoring, and did not indicate why blood glucose levels were not recorded three times per day, as ordered. On December 10, 2024, at 8:40 a.m., R3 stated there were staffing concerns on the evening shift the night before, on December 9, 2024. R3 stated he was concerned his Freestyle Libre sensor was not working properly and requested the employees test his blood sugar with the glucometer. R3 stated the employees did not check his blood glucose last evening, or during the night. R3's record lacked documentation if R3's blood glucose was checked, or why it was not checked, as ordered. On December 10, 2024, at 9:15 a.m., director of operations (DO)-C stated R3 called him last night and voiced concerns about his cares. DO-C verbalized he provided direction to another employee to go over to the facility to assist R3 and the other residents. Additionally, DO-C stated this must not have occurred as he directed. On December 10, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-D were updated on R3's concern he did not have his blood glucose tested last evening as requested. CNS-B and LPN-D verbalized they would review this and follow up with R3 and the employees. LPN-D stated two of the employees who worked last night had been trained and competency tested on blood glucose testing. Both CNS-B and LPN verbalized they planned to follow up on the incident report. On December 11, 2024, at 10:20 a.m., CNS-B and LPN-D stated R3 often is out of the home on	01960		

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01960	Continued From page 31 leave of absence at times during the day. CNS-B verbalized the BG test order for R3 indicated to be completed three times daily before meals. Also, CNS-B and LPN-D stated they planned to review this order with the provider and provide additional education for the employees on documentation. The licensee's Treatment Documentation policy, dated June 20, 2024, indicated "1. All staff members providing care to residents at [Licensee] are required to document every instance of care, treatment, or intervention in the RTask charting system. 2. Documentation must be completed in real-time or as soon as possible after the care or treatment is rendered to ensure accuracy and completeness. 3. The documentation should include, but is not limited to, the following details: -Date and time of care/treatment. -Type of care/treatment provided. -Any observations, changes, or resident responses. -Staff initials or signatures." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *12/10/24*
Time: 09:21:30
Report: 1018241217

Food and Beverage Establishment Inspection Report

Location:
The Geneva Suites
6222 Braeburn Circle
Edina, MN55439
Hennepin County, 27

Establishment Info:
ID #: 0039321
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122088888
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER`
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ EGGS
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A TWO BASIN SINK AND A DEDICATED HAND WASHING SINK.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE AND PROPER TEMPERATURE WAS CONFIRMED WITH TEMP STRIP.

Food and Beverage Establishment Inspection Report

FOOD COMES IN THROUGH THEIR OWN PRIVATE SUPPLIER AND IS SOMETIMES HOT HELD FOR RESIDENTS.

VIEWED HOT AND COLD HOLDING LOGS.

VIEWED EMPLOYEE ILLNESS LOG.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018241217 of 12/10/24.

Certified Food Protection Manager: LESLIE N KEMP

Certification Number: FM112097 Expires: 07/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

LESLIE KEMP
KITCHEN MANAGER

Signed: 

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us