DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 10, 2022

Administrator
The Geneva Suites
6222 Braeburn Circle
Edina, MN 55439

RE: Project Number(s) SL33436015-1

Dear Administrator:

On January 7, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 19, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

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Electronically Delivered
October 7, 2021

Administrator
The Geneva Suites
6222 Braeburn Circle
Edina, MN 55439

RE: Project Number(s) SL33436015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 19, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 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 the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

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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 _____	09/19/2021

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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL33436015 On September 15, 2021, through September 17, 2021, surveyors of this Department's staff visited the above provider and the following correction orders were issued. At the time of the survey, there were six (6) residents receiving services under the Assisted Living license.	0 000	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.	
0 480 SS=F	144G.41 Subdivision 1 Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 1 (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all six (6) residents of the facility. 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 additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated September 15, 2021. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 2 (21) days	0 480		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a resident council, and develop a process to consider resident council recommendations and grievances. This had the potential to affect all six (6) residents receiving assisted living services. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect 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:	0 530		

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0 530	Continued From page 3 On September 15, 2021, at approximately 10:30 a.m. during the entrance conference, the director of nursing (DON) stated they had not attempted to establish a resident council at this time. A resident council policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 530		
0 540 SS=C	144G.41 Subd. 6 Family councils The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a family council, and develop a process to consider council recommendations and grievances. This had the	0 540		

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0 540	Continued From page 4 potential to affect all six (6) residents receiving assisted living services. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect 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 September 15, 2021, at approximately 10:30 a.m., during the entrance conference, the director of nursing (DON) stated they had not attempted to establish a family council at this time. A family council policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 540		
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 e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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	0 550		

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0 550	Continued From page 5 to the Minnesota Adult Abuse Reporting Center. 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 and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all six (6) residents receiving assisted living services. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect 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: The licensee lacked a posting in a common area of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of posting in the common area of contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On September 15, 2021, during a facility tour at approximately 10:45 a.m., an observation was made of the facility's common areas and noted to lack the required posting of the grievance procedure and Ombudsman contact information. During an interview on September 15, 2021, at 12:29 p.m., the director of nursing (DON) verified	0 550		

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0 550	Continued From page 6 the required information was not posted in the common areas of the facility. The provided Concern Resolution policy dated July 29, 2021, did not address requirements for posting contact information in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all six (6) residents	0 640		

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0 640	Continued From page 7 receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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 clients). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. In addition, there was no evidence of the contact information or reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). On September 15, 2021, during a facility tour at approximately 10:45 a.m., an observation was made of the facility's common areas and noted to lack the required posting of the emergency number and information related to reporting suspected maltreatment to MAARC. During an interview on September 15, 2021, at 12:29 p.m., the director of nursing (DON) verified the required information was not posted in the common areas of the facility. The provided Vulnerable Adult policy, dated July 29, 2021, did not address requirements for posting contact information in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

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0 660	Continued From page 8	0 660		
0 660 SS=F	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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment. 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 is 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:	0 660		

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0 660	Continued From page 9 During the entrance conference on September 15, 2021, at approximately 10:40 a.m. with registered nurse (RN-C), a request was made to review the facility TB risk assessment. DON stated a facility TB risk assessment had been completed sometime in 2018 but they did not have a recent TB risk assessment completed. The licensee's TB Prevention and Control policy, dated July 11, 2016, noted the administrator would be responsible for conducting the risk assessment and the TB Prevention Plan and Risk Assessment would be reviewed every other year. 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 a TB infection control program should include a facility TB risk assessment. The guidelines also indicated 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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 10 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) 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 facility failed to maintain functioning smoke alarms in the lower level hallway in proper continuous working order as required. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client'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	0 780		

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0 780	Continued From page 11 situation has occurred only occasionally). The findings include: On September 15, 2021, at approximately 11:30 am while touring with the Administrator, it was observed that the lower level of the facility was in the state of construction/remodeling with multiple nonfunctioning smoke alarms installed throughout the ceiling. This was verified with the Administrator and she stated that she will have the maintenance person look into the smoke alarms and repair them. Nonfunctioning smoke alarms prevent early notification of smoke and/or fire which can delay response time for evacuation of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, portable fire extinguishers were not being maintained and installed properly. This had the potential to	0 790		

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	33436	A. BUILDING: _____ B. WING _____	09/19/2021

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

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0 790	Continued From page 12 directly affect all residents and staff. 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 September 15, 2021, between 9:30 a.m. and 12:30 p.m., survey staff toured the facility with the Administrator. KITCHEN PORTABLE FIRE EXTINGUISHER On September 15, 2021, at approximately 10:30 am, the Administrator located the first portable fire extinguisher inside the bottom of the kitchen cabinet. This extinguisher neck had a tag with the required annual verification of service dated February 2021, but no records or tags of required monthly inspection necessary for designated location, verifation that the extinguisher has not been tempered with, or condition of it to prevent its operation were available for review. MAIN FLOOR PORTABLE FIRE EXTINGUISHER On September 15, 2021 at approximately 10:30 am, the Administrator had difficulty locating the portable fire extinguisher on the main floor as the it was not visibly seen. We were able to locate it in the hallway closet later at approximately 11:00 am during the tour of the main floor. It was observed and verified with the Administrator that the extinguisher did not bear any tags, label, or records of verification of service maintenance and required inspection was performed. Unmaintained portable extinguisher do not provide the ability to extinguish a fire when necessary.	0 790		

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0 790	Continued From page 13 LOWER LEVEL PORTABLE FIRE EXTINGUISHER On September 15, 2021 at approximately 11:30 am, the Administrator had difficulty locating the portable fire extinguisher for the lower level floor, but she was able to locate it under some construction materials on the floor in the corner of the lower level after searching for the extinguisher. It was observed and verified with the Administrator that the extinguisher did not bear any tags, label, or records of verification of service maintenance and required inspection was performed. Unmaintained portable extinguisher do not provide the ability to extinguish a fire when necessary. IMPROPER LOCATION and INSTALLATION OF PORTABLE FIRE EXTINGUISHERS On September 15, 2021 between 9:30 am and 12:30 pm, all three portable fire extinguisher locations were observed to be obscured from view and improperly installed or secured per the manufacturer's installation instructions as required by the State Fire Code. Improper location and installation of portable fire extinguishers restricts immediate access and do not provide the ability to extinguish a fire when necessary. Not further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800		

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0 800	Continued From page 14 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility was not being maintained in a continuous state of good repair and operation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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 clients). The findings include: On September 15, 2021, between 9:30 a.m. and 12:30 p.m., survey staff began the tour with the Administrator. The following observations were made during the facility tour: a. On September 15, 2021, at approximately 11:00 a.m, it was observed the resident room identified as orange room consists of heavily soiled carpet and dismantled fire sprinkler head. The Administrator stated that they frequently clean the carpet as needed. b. On September 15, 2021, at approximately 11:10 a.m, it was observed the screen door to the deck of resident room identified as green room was jammed and unable to open. The Administrator stated that it's on the list being repaired by the repair person.	0 800		

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0 800	Continued From page 15 c. On September 15, 2021, at approximately 11:30 a.m it was observed in the lower level floor to consists of open sewer pipes and improper sewer caps from construction that was connected to the existing plumbing system. These open sewer piping and improper sewer caps will cause sewer gas to leak and enter the building environment which has potential to harm residents and staff. The Administrator stated that the construction has stopped and that the city has withdrawn the permit for construction. She also confirmed a couple of sewer pipes were opened. d. On September 15, 2021, between 11:30 am and 12:00 pm, it was observed the lower level is open to the main floor through an unenclosed stairway, and the lower level is in the state of construction with exposed sand, unfinished plumbing, and other unfinished conditions. These conditions failed to protect the residents from potential construction dusts from the lower level as well as potential changes to the heating and ventilation system from the unfinished construction in the lower level. The Administrator stated that the building permit for the remodel for the additional four bedrooms has stopped and the city has withdrawn the permit for construction at this time. The lower level must be reviewed with the city for final inspections and/or as necessary closed out all construction permits to ensure and keep the building and equipment in continuous state of good repair and operation with regards to health, safety and well-being of residence. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 16	0 810		
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; (2) employee 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) Employees 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 employees 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 interview and record review, the facility failed to provide the required documentation on	0 810		

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0 810	Continued From page 17 fire safety and evacuation procedures, evacuation drills, staff training, and training plan frequency related to evacuation. In addition, the facility failed to provide documentation on resident training on proper actions and training plan frequency related to evacuation of the residents that are capable of assisting their own evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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 clients). The findings include: On September 15, 2021, between 9:30 a.m. and 12:30 p.m., survey staff toured the facility with which included document review. Survey staff requested the facility fire safety and evacuation plans for review. EVACUATION PLAN The facility documentation failed to provide the following: a. It was observed that color identifiers referred by the Administrator for resident rooms were not provided in hallways or on doors, and the color identifiers do not match the numbers shown on the posted evacuation floor plan. b. Documentation or plan of the facility's fire safety and evacuation plans on specific procedures for employee fire drill actions. c. Specific documentation on fire protection procedures necessary for residents including their movements, and relocation during a fire or similar	0 810		

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0 810	Continued From page 18 emergency, and written instructions for addressing unique situations for residents who are needing assistance during evacuation especially for residents who are needing assistance during evacuation were not available for staff review. On September 15, 2021, at approximately 10:30 a.m, the Administrator stated that the evacuation floor plan with was posted near the front entrance door and acknowledged that no other documentation on fire safety and evacuation was available. EVACUATION DRILLS The facility failed to provide and documented the required employee evacuation drills. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month, totally, six minimum required total number of employee evacuation drills per year. On September 15, 2021, approximately 10:30 a.m. The Administrator was not able to provide the records of the required evacuation drills as requested. TRAINING The facility failed to provide documentation for the following: a. The required records on training of employees on fire safety and evacuation. b. The required records on training of residents who are capable of assisting their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, or relocation. On September 15, 2021, approximately 10:30 a.m. The Administrator was not able to provide	0 810		

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0 810	Continued From page 19 the records of training of employees and residents as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered	01440		

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01440	Continued From page 20 nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee(ULP-B) with employee record reviewed. 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 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). The findings include: Unlicensed personnel (ULP)-B began providing assisted living services for the provider on August 9, 2021. ULP-B's employee record lacked evidence the RN conducted direct supervision of the employee performing a delegated task within 30 days the employee had first performed the delegated task for residents. RN-C stated ULP-B had been instructed to perform compression stocking application, indwelling catheter maintenance, oxygen administration, and blood glucose monitoring and had completed these tasks. RN-C was asked what the process was for the RN to conduct a supervisory visit for an employee performing a delegated task. RN-C stated there was no formal process for conducting supervision of a ULP performing a delegated task. RN-C also stated all employees were monitored by the RN's when they were working with that employee, to ensure the employee was completing the delegated task. RN-C stated there was no documentation to show this was completed by the RN.	01440		

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01440	Continued From page 21 The licensee's Delegation of Home Care Tasks dated July 11, 2016, indicated if a home health aide had not regularly performed a delegated home care task for a period of 24 consecutive months, the home health aide would demonstrate competency in the task to the RN prior to performing the task.. The licensee's Service Plan Agreement, undated, identified staff would be supervised within 30 days of hire and periodically thereafter. The service plan also noted all monitoring, reassessment and supervision of staff would be done by a licensed nurse and the method of monitoring reviews or assessments would be noted on the monitoring and reassessment form. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 22 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conduct ongoing client monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted October 8, 2019, and had diagnoses to include quadriplegia and diabetes. R1's record included documentation of a comprehensive nursing assessment completed June 12, 2021. No further assessment was documented in R1's chart.	01620		

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01620	Continued From page 23 During an interview on September 16, 2021, at 10:28 a.m. RN-C verified R1's assessment dated June 12, 2021, was the most recent one. RN-C indicated R1 was scheduled for his next assessment on that day (September 16, 2021 - 96 days after the previous assessment) because the registered nurse (RN) responsible for the reassessment only worked on Thursdays. The licensee's Assessment-Comprehensive Services policy dated July 11, 2016, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client, but cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650		

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01650	Continued From page 24 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R2) with records reviewed. 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: R2's service plan lacked the following: -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650		

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01650	Continued From page 25 and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2's diagnoses included, morbid (severe) obesity with alveolar hypoventilation. R2s service plan agreement, signed December 21, 2018, indicated services included medication administration, bathing, assistance with dressing, grooming, continence care. The service plan agreement indicated a name and phone number for an emergency contact but lacked any information in regards who had the authority to sign for the resident in an emergency. The service plan agreement also lacked information indicated if resident had a health care directive or not and when emergency services were not to be summoned. On September 16, 2021, at approximately 12:40 p.m. registered nurse (RN)-C stated the service plan had been completed on December 21, 2018, and there were no changes to the service plan since the date of the signing. RN-C stated the service plan lacked the above required content. In addition, RN-C stated the same format would be utilized for all residents. The licensee's Service Plan policy, updated July 29, 2021, noted the service plan included: -Information and method for a resident or resident representative to contact the home care provider. -Names and contact information of persons the resident would want to have notified in an emergency or if there were a significant adverse change in the residents condition, including identification of and information as to who would	01650		

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 _____	09/19/2021

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
01650	Continued From page 26 have the authority to sign for the resident in an emergency. -Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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 _____	09/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 27 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include in the service plan an individualized medication management plan with the following required content for one of one resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Service Plan indicated the resident received medication administration six times per day and as needed. The resident Service Plan and record	01730		

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 _____	09/19/2021

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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
01730	Continued From page 28 lacked evidence of: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis; -procedure for staff notifying a registered nurse or appropriate licensed health professional when a problem arose with medication management services; -any resident specific requirements relating to documenting medication administration, verifications that all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R2's diagnoses included but were not morbid (severe) obesity with alveolar hypoventilation. R2's medication and treatment administration record dated September, 2021, indicated staff were administering medications six times per day to R2. During interview, registered nurse (RN-C) stated there is a section on the assessment indicating what medication services the client would receive and that is based on the medication assessment. RN-C also stated the service plan indicated the resident received medication administration six times per day and as needed. RN-C acknowledged the service plan did not include the above information. A Medication Management Plan policy was	01730		

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 _____	09/19/2021

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THE GENEVA SUITES	6222 BRAEBURN CIRCLE EDINA, MN 55439

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01730	Continued From page 29 requested but not received. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		
01880 SS=F	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 facility failed to store all prescription medications according to the manufacturer's directions for two of two clients (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: R1 had diagnoses to include quadriplegia and diabetes. R2 had diagnoses included morbid (severe) obesity with alveolar hypoventilation R2's medication and treatment administration	01880		

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 _____	09/19/2021

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01880	Continued From page 30 record dated September, 2021, indicated staff were administering medications six times per day to R2. On September 15, 2021, at 12:17 p.m., registered nurse (RN)-A was observed to administer 4 units of insulin via NovoLOG FlexPen 100 unit/ml to R1. On September 16. 2021 at approximately 10:45 a.m., RN-C was asked to indicate where medication refrigerator was located. RN-C escorted writer to the garage where there was a dorm size refrigerator and separate dorm size freezer. Inside refrigerator were 3 boxes of pen style insulin. When asked if there was a thermometer, DON could not locate one but stated she would look into where it would be. Freezer noted to have an automatic thermometer located on the front of the freezer. Freezer temperature read (-1) degree Fahrenheit. At approximately 11:25 a.m., writer requested RN-C escort to medication refrigerator again as writer heard conversation between LPN and RN-C stating there was an actual thermometer in the refrigerator. RN-C brought writer and opened refrigerator in which there was a thermometer sitting on the middle rack of the refrigerator. RN-C stated the thermometer had been on the refrigerator door the whole time and she moved it to the middle rack. Writer observed temperature of thermometer to be 48 degrees Fahrenheit. RN-C stated she believed the temperature was not correct as the door to the refrigerator had been open so many times. States when she moved it from the door to the middle rack the temperature read 36 degrees Fahrenheit.	01880		

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01880	Continued From page 31 The licensee's "Storage/Control of Medications" policy dated July 1, 2016, indicated medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods at a temperature maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 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	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 _____	09/19/2021

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01940	Continued From page 32 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 a treatment management plan to include all required content and/or revised as need for one of one residents (R2) reviewed receiving treatments. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's Service Plan was not completed to reflect the current treatments the resident was receiving. The service plan indicated the resident received treatments daily but did not indicate what treatment the resident was receiving. R2's diagnoses included but were not morbid (severe) obesity with alveolar hypoventilation. On September 15, 2021, at approximately 11:40 a.m. writer observed R2 sitting in a wheelchair and was noted to have a indwelling Foley catheter drainage bag. When interviewed, R2 stated that the nursing assistants do the cares for	01940		

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	33436	A. BUILDING: _____ B. WING _____	09/19/2021

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01940	Continued From page 33 her catheter and a nurse changes the catheter when needed. R2's medication an treatment administration record dated September, 2021, indicated staff were to clean at catheter site every fours hours while repositioning at night when client is awake. Staff are instructed to clean around the catheter by holding onto the top of the catheter closest to the urethra and taking a cleansing cloth and wiping in a downward motion. During interview, registered nurse (RN-C) stated there was a section on the assessment indicating what treatments the client had received and the service plan indicated the client was receiving treatments daily. RN-C also stated the service did not specify what treatments were being completed. A Treatment and Therapy Management Plan policy was requested but not provided. No further information is available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02240	Continued From page 34 of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current "Minnesota	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE GENEVA SUITES	6222 BRAEBURN CIRCLE EDINA, MN 55439

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02240	Continued From page 35 Bill of Rights for Assisted Living Residents" was provided to the resident and a written acknowledgement received for one of one resident (R-2) with records reviewed. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect 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: R-2 began receiving assisted living services on December 27, 2018. The resident's record lacked evidence of a current bill or rights, a written acknowledgement, and the process for filing a complaint. Resident record noted to have a signed Minnesota Home Care Bill of Rights dated January, 2014. During interview September 16, 2021, at approximately 1:10 p.m. registered nurse (RN-C) stated the administrator notifies residents and resident representatives via email when a new Minnesota Home Care Bill of Rights is published. RN-C stated administrator emails them a copy. RN-C also stated there is not signed documentation from residents or resident representatives that they have read and acknowledge they have received a current publication. The licensee's Notifications Policy, dated July 11, 2016, indicated the agency will obtain written acknowledgment of the resident ' s receipt of the assisted living bill of rights, notice of privacy and the statement of services provided/not available	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02240	Continued From page 36 from the resident or the resident ' s representative or document why an acknowledgment could not be obtained. Documentation of the acknowledgment will be retained in the resident ' s clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/15/21*
Time: 09:30:00
Report: 1005211202

Food and Beverage Establishment Inspection Report

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

Establishment Info:
ID #: N#N0001
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/21

Operator:

Phone #:
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.

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

TCS FOODS IN THE KITCHEN COOLER WERE NOT DATE MARKED, INCLUDING HAM, PASTA, WATERMELON, AND MILK. DISCUSSED REQUIREMENT FOR MARKING TCS FOODS TO ENSURE THEY ARE USED OR DISCARDED WITHIN 7 DAYS OF OPENING. FACT SHEET SENT WITH REPORT.

Comply By: 09/15/21

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

THERE IS NO THERMOMETER OR TEMPERATURE STRIPS FOR THE DISH MACHINE. PROVIDE A MAXIMUM REGISTERING THERMOMETER OR DISPOSABLE TEMPERATURE SENSITIVE STRIPS TO ENSURE THE DISH MACHINE IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

Comply By: 09/22/21

Type: Full
Date: *09/15/21*
Time: 09:30:00
Report: 1005211202
The Geneva Suites Braeburn Hom

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO MN CFPM ON SITE. HAVE AN EMPLOYEE TAKE AN APPROVED FOOD SAFETY COURSE, AND APPLY FOR CERTIFICATION. FACT SHEET SENT WITH REPORT.

Comply By: 10/15/21

Food and Equipment Temperatures

Process/Item: Cold Hold/HAM
Temperature: 37 Degrees Fahrenheit - Location: FRIGIDAIRE KITCHEN COOLER
Violation Issued: No

Process/Item: Cold Hold/PASTA
Temperature: 38 Degrees Fahrenheit - Location: FRIGIDAIRE KITCHEN COOLER
Violation Issued: No

Process/Item: Cold Hold/WATERMELON
Temperature: 40 Degrees Fahrenheit - Location: FRIGIDAIRE KITCHEN COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: FRIGIDAIRE KITCHEN COOLER
Violation Issued: No

Process/Item: Cold Hold/POTATO SALAD
Temperature: 29 Degrees Fahrenheit - Location: REFRIGERATOR - GARAGE
Violation Issued: No

Process/Item: Cold Hold/PORK CHOP
Temperature: 31 Degrees Fahrenheit - Location: REFRIGERATOR - GARAGE
Violation Issued: No

Process/Item: Cold Hold/RICE
Temperature: 29 Degrees Fahrenheit - Location: REFRIGERATOR - GARAGE
Violation Issued: No

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

INSPECTION COMPLETED WITH EMPLOYEES AND MANAGER. DISCUSSED ORDERS ON REPORT.

ALSO DISCUSSED:
-ELIMINATING BARE HAND CONTACT WITH READY TO EAT FOODS
-HANDWASHING
-EMPLOYEE ILLNESS
-PROPER COOK TEMPERATURES FOR RAW ANIMAL FOODS

Food and Beverage Establishment Inspection Report

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 1005211202 of 09/15/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
CATHERINE DECKER

Signed:_____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us

Report #: 1005211202

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	2	Date 09/15/21
No. of Repeat RF/PHI Categories Out	0	Time In 09:30:00
Legal Authority MN Rules Chapter 4626		Time Out

The Geneva Suites Braeburn Hom	Address: 6222 Braeburn Circle	City/State: Edina, MN	Zip Code: 55439	Telephone
License/Permit #: N#N0001	Permit Holder	Purpose of Inspection: Full	Est Typo	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS= corrected on-site during inspection R= repeat violation

Compliance Status		COS	R
Supervision			
1 (IN) OUT	PIC knowledgeable; duties & oversight		
2 IN (OUT) N/A	Certified food protection manager, duties		
Employee Health			
3 (IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 (IN) OUT	Proper use of reporting, restriction & exclusion		
5 (IN) OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 (IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 (IN) OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 (IN) OUT N/O	Hands clean & properly washed		
9 IN OUT N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 (IN) OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 (IN) OUT	Food obtained from approved source		
12 IN OUT N/A (N/O)	Food received at proper temperature		
13 (IN) OUT	Food in good condition, safe, & unadulterated		
14 IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 (IN) OUT N/A N/O	Food separated and protected		
16 (IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17 (IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A (N/O)	Proper cooking time & temperature		
19 IN OUT (N/A) N/O	Proper reheating procedures for hot holding		
20 IN OUT (N/A) N/O	Proper cooling time & temperature		
21 IN OUT (N/A) N/O	Proper hot holding temperatures		
22 (IN) OUT N/A	Proper cold holding temperatures		
23 IN (OUT) N/A N/O	Proper date marking & disposition		
24 IN OUT (N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 (IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT (N/A)	Food additives: approved & properly used		
28 (IN) OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.
Mark "X" 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
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls: _____

Person in Charge (Signature) Date: 09/15/21

Inspector (Signature) Jessica Dan