DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336808363M **Date Concluded:**
Compliance #: HL336809942C

Name, Address, and County of Licensee Investigated:
The Geneva Suites
2309 Wildwood Ct
Burnsville, MN 55306
Dakota County

Facility Type: Assisted Living Facility (ALF) **Evaluator's Name:** Deb Schillinger RN BSN
Special Investigator

Finding: Inconclusive

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
Allegation #1
The alleged perpetrator (AP) abused the resident when he scrubbed the resident's backside causing open sores.

Allegation #2
The facility neglected the resident when it did not provide adequate wound care leading to an infection.

Investigative Findings and Conclusion:
Allegation #1
The Minnesota Department of Health determined abuse was inconclusive. Although the care provided was reported to be uncomfortable or painful for the resident, the AP denied intentionally causing harm or pain while providing care to the resident.

Allegation #2
The Minnesota Department of Health determined neglect was not substantiated. While it is true the resident did have a wound, the infection present upon hospital admission was not due to the wound, but rather a urinary tract infection. The facility coordinated care with the hospice provider that was managing the wound.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice provider. The investigation included review of the resident record, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed resident and facility staff interactions during an onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included quadriplegia secondary to cerebral palsy, recurrent urinary tract infections, heart failure, and clostridium difficile infection (a severe bacterial infection of the colon, often after antibiotic use, that causes diarrhea, fever, nausea and abdominal pain). The resident's service plan included assistance with medication management, transferring, mobility, and toileting. The resident's assessment indicated mild cognitive impairment, mechanical lift for transfers, was dependent on wheelchair for mobility and had contractures in upper and lower extremities. The resident was also receiving hospice services for end-of-life care, which included wound care.

Allegation #1
A concern arose one Friday when a report was received that the AP had "scrubbed" the residents bottom when providing incontinent care and caused open wounds.

The facility internal investigation indicated unlicensed caregiver #1 reported the AP was physically aggressive while providing incontinent care and wiped her "so hard it made her cry". The same document indicated the AP also verbally abused the resident by saying "she would infect other residents, and they would die".

The AP was an unlicensed caregiver who provided cares for the resident. The resident records indicated the AP was providing care for the resident the day of the incident.

Payroll documents indicated the AP worked the day shift the day the of the incident. The same document indicated that unlicensed caregiver #1 worked the overnight shift the day of the reported incident.

Three days after the reported incident, on Monday, the residents progress notes indicated the nurse provided the resident incontinent cares. Documentation indicated the resident had redness and rawness to her buttocks area but did not indicate open areas. The same note indicated the resident complained of severe pain that the nurse treated with pain medication and barrier cream to the affected area.

Payroll documents indicated the AP worked the day shift on the day the of the incident. The same document indicated unlicensed caregiver #1 worked the overnight shift on the day of the reported incident.

There were no notes on the day of the incident, the resident went to the hospital 6 days after the incident was reported to have occurred.

During an interview, the AP stated he previously worked at the facility as an unlicensed caregiver. He stated he had arrived to work that day and was the only caregiver when the facility normally staffed two caregivers. The AP denied physically or verbally abusing the resident. The AP stated the resident had multiple incontinent episodes and was not trying to hurt the resident but did use wipes to provide incontinent care.

The resident was deceased at the time of the investigation.

Attempts to reach ULP #1 were unsuccessful.

Allegation #2
A concern arose that adequate wound care was not provided to the resident that led to an infection and hospitalization.

The resident's medical record indicated six weeks before the hospitalization the resident was seen in the emergency department for an infection, where an antibiotic was ordered and the resident began having diarrhea two days later. The facility documented ongoing coordination of care with the hospice provider for unmanaged diarrhea.

The resident's medical record indicated two weeks before the hospitalization during a provider appointment, the resident was diagnosed with a clostridium difficile infection and prescribed an antibiotic to treat the infection. Four days after the provider visit, the family member delivered the prescribed medication to the facility. The facility nurse confirmed the medication order with the provider and hospice, then administered the medication as ordered to the resident.

The electronic medication administration record (EMAR) indicated the resident received nine days of the ordered antibiotic until again transported to the emergency department for ongoing nausea, vomiting and diarrhea. The resident was then admitted to the hospital for dehydration.

A progress note dated four days before the hospital admission indicated the facility nurse documented the residents skin was raw and red after an episode of diarrhea but did not indicate open pressure area. The same note indicated that barrier cream was applied, education was provided to staff, and the hospice provider was updated.

The resident's medical record indicated wound care was provided and managed by the hospice provider.

The hospital records indicated on admission the resident had an unresolved clostridium difficile infection, a stage 2 pressure ulcer (a partial-thickness skin injury presenting as a shallow red or pink wound bed) to left buttock, and failure to thrive.

The facility's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated wound care is not a service provided by the facility and requires a care partner to provide and manage wounds.

The resident's cause of death worksheet indicated the resident's primary cause of death was coronary artery disease and the manner of death was natural causes.

During an interview, the nurse stated the hospice provider managed the resident's wounds and the facility coordinated care and symptom management with the hospice provider and the resident's medical provider.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

Allegation #1
Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Allegation #2
"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(4) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult which does not result in injury or harm which reasonably requires medical or mental health care; or
(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:
(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, resident is deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
An internal investigation was completed, the AP is no longer employed at the care facility.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33680	A. BUILDING: ______ B. WING ______	C **02/18/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	**2309 WILDWOOD COURT** **BURNSVILLE, MN 55306**

(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 On February 18, 2026. , the Minnesota Department of Health initiated an investigation of complaint #HL336809942C/#HL336808363M. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE