Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343212460M
Compliance #: HL343218900C

Date Concluded: August 10, 2026

Name, Address, and County of Licensee Investigated:
The Geneva Suites
11416 Wild Heron Point
Eden Prairie, MN 55347
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Maerin Renee, RN, 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):
The facility neglected the resident when a medication he required for a bowel program was not administered. The resident experienced severe constipation which required hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Due to miscommunication among facility staff, the resident did not receive Movantik (a medication used to treat opioid-induced constipation in adults with chronic, non-cancer pain) for an extended period. The resident experienced constipation and received an enema at his clinic, after which he returned to the facility. The facility improved protocols to ensure the timely ordering and delivery medications, including Movantik. However, given the resident's extensive bowel management plan, it could not be determined if missing doses of Movantik was directly responsible for the resident developing constipation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted case management. The investigation included review of the resident record, clinic records, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed medication passes, resident cares and staff interactions with residents.

The resident resided in an assisted living facility. The resident's diagnoses included Guillain-Barre syndrome and chronic pain. The resident's services included assistance with activities of daily living, meals, and medication management. The resident's assessment indicated the resident required full assistance with most activities of daily living, but was independent with managing health issues, making appointments, and decision-making.

The resident's progress notes indicated he complained of constipation and had not had a bowel movement in approximately one week. Upon review, it was noted the resident's Movantik had not been available for administration since the previous month due to Movantik requiring a refill authorization. The resident utilized several medications to manage his bowel program, and at that time the Movantik was re-ordered.

The resident's medical record indicated the resident was seen in his clinic for obstipation (a form of constipation where an individual cannot pass stool or gas due to a mass blocking the bowel), nausea, and abdominal pain. The resident had also been seen in the clinic two years prior for the same issue. At that time, he received an enema and was sent home. During the current visit, imaging revealed abundant stool filling the end of the resident's colon and rectum, like his exam two years prior. The rest of the colon was unremarkable and there was no small bowel obstruction. The resident received a soap suds enema which triggered a bowel movement. The resident was discharged back to the facility with instructions to return if there were worsening or concerning symptoms. He was instructed to continue his bowel regimen and follow up with his primary care provider as needed.

The resident's medication administration record (MAR) indicated he used several medications as part of his bowel management program. The medications included both scheduled and as-needed (PRN) medications such as Linzess (to treat constipation), and laxatives such as Fiberlax, polyethylene glycol, and senna. The resident also used suppositories and Fleet enemas, as well as the stool softener, Reguloid. The resident's MARs indicated he did not take Movantik regularly as scheduled for two months prior to the incident. After obtaining the medication, then he resumed Movantik on a regular basis.

When interviewed, a nurse said Movantik was a new medication for the resident, and it was impossible to say the Movantik running out caused the resident's constipation. The resident was quadriplegic, and he used many medications as part of his bowel management regimen. The Movantik was not on a regular cycle refill and needed to be requested from the pharmacy every 14 days. Caregivers had charted the Movantik was out of stock, but they did not notify nursing. Many caregivers believed when they charted medication was not available, that

information was relayed directly to nursing, which it was not. Caregivers were re-educated about the process of notifying nursing when medications needed to be re-ordered, and the nursing team followed the status of the Movantik supply more closely. The pharmacy also began to alert the facility of any changes. After those process improvements were made, there were no further issues regarding the resident's Movantik supply.

When interviewed, the resident said constant staff changes led to a lack of continuity from one administration to the next, and much information was lost in the shuffle. The resident described the management of the facility as "abominable" and did not believe caregivers should be shouldered with the responsibility of keeping track of medications to notify nursing. The resident said currently his medication management was still a "mixed bag," but he had no issues with the pharmacy.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

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.

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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, the resident is his own decision-maker.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility re-educated staff and developed new processes for ordering and receiving medications.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34321	A. BUILDING: _____ B. WING _____	C 07/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	11416 WILD HERON POINT EDEN PRAIRIE, MN 55347

(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 July 21, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL343218900C/#HL343212460M. No correction orders are issued.	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.	