Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL397717642M
Compliance #: HL397713180C

Date Concluded: March 17, 2025

Name, Address, and County of Licensee Investigated:
Genesis Group Home
1019 Madison St. South
Shakopee, MN 55379
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

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 by failing to provide oxygen service at night.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident was discharged from the hospital with 2 liters of oxygen to be administered via nasal cannula at night. A fax was sent to the respiratory provider, but it was delayed until after the resident passed away.

The investigator conducted interviews with facility staff manager, family member and hospital staff. The investigation included review of the resident's records, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses schizo-affective disorder, chronic obstructive pulmonary disease (COPD) and aspiratory pneumonia. The resident's assessment indicated he was oriented to person, place, and time and participated in decision-making although he required cues and supervision.

A concern arose when the resident's oxygen was not available in the facility to be used. The resident's progress notes indicated he was discharged from the hospital on a Wednesday. According to the discharge orders from the hospital physician, the resident was to receive 2 liters of oxygen via nasal cannula at night.

The notes further indicated on Thursday, the oxygen provider contacted the facility to inquire about the oxygen order, as they had not received it from the hospital. The facility also did not have the order and reached out to the hospital to request it.

On Thursday night, the resident's progress notes indicated that his oxygen saturation was at 88%. The manager informed the resident he would need to go to the hospital later that night due to the absence of the prescribed oxygen. However, the resident refused. The manager then called the hospital again to ensure the order was faxed to the oxygen provider.

The following morning, around 8:30 AM, a staff member found the resident deceased in their room.

The death certificate listed the cause of death as natural causes.

During an interview, the family member stated the facility inquired about the oxygen delivery status as it had been delayed in arriving for an unknown reason. Overall, he was happy with the service the facility provided to the resident.

During an interview, the manager stated that the oxygen provider called her to ask about the oxygen order, but she did not have it. As a result, she contacted the hospital and requested that the order be faxed over to ensure the oxygen would be delivered. The hospital confirmed they would fax the order; however, the oxygen was not delivered for two nights following the resident's discharge until the resident passed away.

During an interview, the hospital staff stated that when the resident was discharged, they faxed all the orders to the oxygen provider. The next day, they received a call from the oxygen provider stating that the order was missing, so they faxed it again. On Friday, while calling the oxygen provider to confirm the orders, she was unaware that the resident had already passed away. She stated that the hospital did not have any direct communication with the facility, so she did not know what actions the facility took to care for the resident when the oxygen was not delivered.

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

"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.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: No action required.

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
	39771	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS ASSISTED LIVING LLC	1019 SOUTH MADISON STREET SHAKOPEE, MN 55379

(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 March 11, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL397717642M/HL397713180C. No correction orders are issued.	0 000		