STATE LICENSING COMPLIANCE REPORT

Report #: HL32138001C

Date Concluded: December 17, 2021

Name, Address, and County of Facility Investigated:
The Geneva Suites
13909 Frontier Lane
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Carrie Euerle MSN, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

CC:

Office of the Ombudsman for Long Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32138	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	13909 FRONTIER LANE BURNSVILLE, MN 55337

(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.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL32138001C On 12/9/2021, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there was one resident receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued. The following immediate correction order is issued/orders are issued for #HL32138001C, tag identification 1070.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
01070 SS=D	144G.52 Subd. 10 Right to return	01070		

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01070	Continued From page 1 If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow the return of one of one resident (R1) after hospitalization, although the licensee had not issued a notice of termination of services or housing. The licensee told R1's family that they were unable to take R1 back, although the facility UDALSA indicated the licensee could provide the additional services R1 now required. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's medical record was reviewed, which indicated R1 was admitted to the facility on 08/12/2016 with diagnoses which included dementia, vascular disease, history of right hip fracture and incontinence. R1's medical record further included a service plan dated 10/14/2019 which indicated R1 required physical staff assistance of one person for bathing, grooming, dressing, transfers and toileting and R1 also	01070	Minnesota Department of Health is documenting the State Licensing 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	

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01070	Continued From page 2 recieved medication management services. The facility's Uniform Disclosure of Assisted Living Services and Ammenities (UDALSA) dated 5/20/21 indicated the facility would provide staffing to the facility with two staff during the day, two staff during the evening and one staff at night. The UDALSA included the facility was able to provide one and two assist transfers including transfers which required the use of a mechanical lift. Review of R1's progress notes indicated R1 fell on 11/18/2021 at 2:44 a.m. R1 complained of right hip pain, vital signs were taken and the resident was provided as needed pain medication. R1's progress notes included an entry on 11/18/2021 at 4:39 a.m. which indicated R1 continued with complaints of pain, the on-call nurse was called and R1 was sent to the hospital for further evaluation. A progress note dated 11/24/2021 at 4:49 p.m. included that the facility was updated on R1's status by R1's family member who indicated R1 had hip surgery and required the assistance of two staff members for assistance. The facility informed the family they would be unable to accomodate R1's needs due to the change in level of assistance from one to two staff. Facility documents reviewed included emails between R1's family and the senior vice president of people operations (SVP). An email sent to the family on 12/2/2021 from the SVP included that the facility where R1 currently resided could accomodate assistance of one staff	01070	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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01070	Continued From page 3 as of 10/7/2021 and mentioned to the family another facility that would better accomodate the needs of R1 and provide increased social interaction. R1's family member replied to the SVP's email on 12/6/2021 indicating their desire for R1 to return to her current facility. Another email was sent by the family member on 12/7/2021 asking why the facility had not followed this request. An interview with a family member of R1 on 12/8/2021 at 10:55 am indicated the family of R1 had requested the facility to allow for R1 to return to her previous facility and did not want R1 to be moved to another facility owned by the licensee. The family member indicated they were not provided a discharge or termination notice by the facility and were told by a consumer advocate familiar with the situation that the facility is required to allow R1 to return, as they had previously identified they were able to accomodate the needs of a resident with two assist of transfer and the use of a mechanical lift, which R1 now required. The family member indicated the facility had attempted to move R1 prior to R1's fall on 11/18/2021 but the family had declined. The family stated they were not provided at any time a discharge, transfer or termination notice by the facility. Review of R1's medical record lacked documentation of a notification of termination, transfer or discharge. An interview with the SVP and the director of nursing (DON) on 12/9/2021 at 12:13 p.m. indicated they were aware of the family request to move R1 back to her current facility. They indicated they did not have the staffing at the	01070		

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01070	Continued From page 4 facility to meet her needs. The DON indicated she was unaware to the current location of R1. The SVP also indicated the R1's family had not responded to requests for a current contract to be signed, and had not heard from the family of R1. In a follow-up email 12/15/2021 sent to the SVP, the SVP was asked why she had not replied to R1's family's request for R1 to return to the facility. The SVP replied she did not respond to the email as the emails were demanding and she had already explained the facility cannot take R1 back and offered an alternative solution. The SVP did not respond to an email sent questioning if a discharge or termination was provided due to R1's discharge from the facility. A transfer/discharge policy was requested from the facility. The DON indicated the facility's policy was located within the assisted living contract. The facility's assisted living contract indicated the following: prior to initiating a resident transfer, the facility will provide at least thirty (30) calendar days' advance written notice to Resident and Resident's Designated Representative (if applicable) of Provider's intent to transfer Resident, except as otherwise permissible under Minnesota law. In addition, the contract included: the resident has the right to terminate this Contract by providing thirty (30) days prior written notice to the LALD of Provider. This notice period will be shortened to fourteen (14) days in the event of Resident ' s transfer to a facility offering a needed higher level of care than that provided at Provider, or in the event of Resident ' s death. The effective date of the termination must be the last day of a calendar month. In order to be effective, notice must be received on the last day prior to the	01070		

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01070	Continued From page 5 beginning of the thirty (30)-day notice period. Time period for correction: Immediate	01070		