Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL322585041M
Compliance #: HL322586800C

Date Concluded: October 10, 2024

Name, Address, and County of Licensee Investigated:
The Geneva Suites – Lighted Oak
9145 Meadowview Road
Minneapolis, MN 55425
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Christine Bluhm, 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:
The facility neglected the resident when medication orders were not followed, and the resident had uncontrolled pain for 24 hours without relief. The resident missed two doses of methadone.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident received other pain medication until the methadone was started the following day. The resident had numerous medication changes and difficulty with pain management prior to the incident. There were also conflicting accounts of the resident's pain level at that time.

The investigator conducted interviews with multiple facility staff members. The investigator also contacted members of the resident's hospice care team. The investigation included a review of the resident record, facility incident reports, staff schedules, and related facility policy and

procedures Also, the investigator interviewed other residents and observed resident and staff interactions and care as well as mealtime preparation in the home during the onsite visit.

The resident resided in an assisted living facility with a diagnosis of bladder and bone cancer. The resident's service plan included assistance with medications and pain management. The resident's assessment indicated he was alert and oriented and able to communicate his pain. The facility provided coordination of care with the resident's hospice team. The resident's care plan indicated direct care staff were report uncontrolled pain to the nurse.

A concern arose that the resident had uncontrolled pain which prompted hospice to order the pain medication methadone. The hospice pharmacy delivered the medication later that evening, but the resident did not receive the medication.

The resident's progress notes for the same evening indicated direct care staff called the triage nurse to report the resident had pain and requested the as needed oxycodone on his medication list. The nurse directed staff to give the oxycodone and call back in one hour if pain had not improved. There were no other entries documented the remainder of that night.

The following day around 12:30 pm the MAR indicated the facility administered another as needed oxycodone.

The following evening the resident's MAR indicated the methadone was started as prescribed. The same document indicated the facility continued to administer the resident's scheduled and as needed oxycodone as ordered.

The MAR indicated previous entries when care staff contacted nurse triage for the okay to give as needed medications for pain.

During an interview, a nurse stated she took a verbal order for the Methadone earlier the same day from hospice but needed a physician signed "script" faxed to the pharmacy in order to activate the order in the resident's medication record and fill the medication through the facility pharmacy. The nurse stated the methadone was filled later in the evening by the hospice pharmacy, but the direct care staff did not contact the nurse when it arrived.

During interview, the resident could not remember his pain that specific day but stated he had chronic pain that was difficult to get under control.

During interview, a family member stated the resident's care was complex and there were other medication issues besides methadone. She recalled the methadone being ordered and the resident started it the next day. She stated lorazepam (medication used to treat anxiety) was to be discontinued but staff kept giving it when it was obvious he was having severe confusion after taking it. She stated that since the facility used a nurse triage system utilizing many different nurses and the head nurse was there one day a week and it was difficult to

effectively manage his medications. The family member state there were other issues with medications not filled in a timely manner by the facility's pharmacy; staff did not always understand what an "as needed" medications were and meal preparation and food choices were poor and not what they advertised it would be.

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: Yes.
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 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
	32258	A. BUILDING: _____ B. WING _____	C 08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	9145 MEADOWVIEW ROAD BLOOMINGTON, MN 55425

(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 August 19, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL322586800C/#HL322585041M. No correction orders are issued.	0 000		