Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334368927M
Compliance #: HL334366527C

Date Concluded: April 11, 2024

Name, Address, and County of Licensee Investigated:
The Geneva Suites
6222 Braeburn Circle
Edina, MN 55439
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lissa Lin, 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 when he eloped from the building and fell on the street. The resident cut his head and needed stiches.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident was assessed as a fall risk and not always alert and oriented, he had no elopement history. The facility had a door alarm in place that sounded when anyone opened the front door. The resident eloped while staff cared for another resident and did not hear the alarm.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of medical records, reports, policies and procedures, and staff schedules. Also, the investigator observed the resident in his room eating breakfast and visiting with a family member.

The resident resided in an assisted living facility. His diagnoses included a history of TBI (traumatic brain injury), vascular dementia and a history of falling. The resident was on long-term use of blood thinners. The resident's service agreement included assistance with activities of daily living, mobility and medication administration and management. The resident's assessment indicated he had mild cognitive impairment but could make his needs known.

The resident transferred from a sister facility. A few days after he moved in, he eloped through the front door and walked about a half block down the street before he fell. A staff member on his way to work saw the resident and stopped to help him. The resident told the staff member he was out for a walk, lost his balance and fell. He had a bleeding cut on his head. The staff member called 911 and asked a neighbor to let the facility staff know what happened. The resident was seen in the emergency room, received a few stitches and sent home.

During an interview, a manager said the elopement happened around shift change and the two staff members were in a resident room doing cares, so they did not hear the alarm. After the elopement they added a louder 30-second alarm to the front door.

During an interview, the nurse said the resident told her he had just wanted to go for a walk and fell. The nurse said the resident took walks with staff so that was unusual behavior for him. This was his only elopement incident.

During an interview, the resident's family member said the facility did not neglect the resident. He had not eloped before but sometimes talked about going home referring to a place he had lived 30 years ago. The family member said the facility already had a front door chime in place. After the elopement they added a louder alarm system and had staff and visitors enter through the garage to reduce false alarms. The family member said the bigger issues for him were the city and state fire codes which do not allow the facility to lock the front door. The family member said residents exiting a facility are a greater safety concern than fire codes.

The staff member who found the resident did not respond to interview requests.

The resident did not recall the incident and declined an interview.

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, due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility installed an additional alarm at front door and instructed staff to use garage entrance instead of front door. The facility installed a wooden gate across lower half of entrance as an added barrier.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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
	33436	A. BUILDING: _____ B. WING _____	C 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6222 BRAEBURN CIRCLE EDINA, MN 55439

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL334366527C/#HL334368927M On February 14, 2024 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 were five residents receiving services under the provider's Assisted Living Care license. The following correction order is issued for #HL334366527C/#HL334368927M, tag identification 0830.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. 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 Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State 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.	

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0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with all applicable state and local governing laws, regulations, standards, ordinances and codes for fire safety, building and zoning requirements. The licensee began extensive renovation of the building's lower level to increase resident occupancy from 6 to 10 residents in 2021. The City of Edina denied the licensee's request for reasonable accommodation. The licensee stopped the renovation project and failed to remove and clean up construction materials, tools and debris. This had the potential to affect all residents, staff, volunteers and visitors. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: 2021 SURVEY During a survey on September 15, 2021, between	0 830		

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0 830	Continued From page 2 9:30 a.m. and 12:30 p.m., survey staff began the tour with the Administrator. The following observations were made during the facility tour: On September 15, 2021, at approximately 11:30 a.m. it was observed in the lower level floor to consists of open sewer pipes and improper sewer caps from construction that was connected to the existing plumbing system. These open sewer piping and improper sewer caps will cause sewer gas to leak and enter the building environment which has potential to harm residents and staff. The Administrator stated that the construction has stopped and that the city has withdrawn the permit for construction. She also confirmed a couple of sewer pipes were opened. On September 15, 2021, between 11:30 am and 12:00 pm, it was observed the lower level is open to the main floor through an unenclosed stairway, and the lower level is in the state of construction with exposed sand, unfinished plumbing, and other unfinished conditions. These conditions failed to protect the residents from potential construction dusts from the lower level as well as potential changes to the heating and ventilation system from the unfinished construction in the lower level. The Administrator stated that the building permit for the remodel for the additional four bedrooms has stopped and the city has withdrawn the permit for construction at this time. The lower level must be reviewed with the city for final inspections and/or as necessary closed out all construction permits to ensure and keep the building and equipment in continuous state of good repair and operation with regards to health, safety and well-being of residence. 2024 COMPLAINT INVESTIGATION	0 830		

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0 830	Continued From page 3 On February, 2024, at 10:00 a.m., the MDH surveyor toured the licensee with the licensed assistant living director, (LALD)-A. During the tour, the MDH surveyor observed the lower level was open to the main floor through an unenclosed stairway that was secured with a locked metal gate and a sign that said "Employees Only Beyond This Point". During the tour of the lower level, the MDH surveyor observed multiple areas of excavated concrete floor surrounded by piles of gray sand and construction debris (rocks, pieces of wood, concrete chunks, metal and plastic fragments and pieces of insulation). There were unfinished plumbing, framing, and electrical projects. Lumber and other construction materials were stacked in one room. The MDH surveyor observed dust in the air after walking around the lower level. During an interview on February 14, 2024, at 10:00 a.m., LALD-A said the City of Edina pulled their construction permit in 2020 after neighbors complained about potential traffic and parking issues. LALD-A said they had a family ready to move into the lower level but since the construction permit was pulled, they stopped construction and left everything where it was. On February 14, 2024, at 1:48 p.m. the MDH surveyor sent LALD-A an exit email indicating an the on-going construction situation in the lower level was an area of concern and the licensee needed to submit a Construction Submittal Form to MDH. The MDH surveyor also called LALD-A and informed her of the exit email. TIME PERIOD TO CORRECT: Twenty-one (21)	0 830		

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