Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL338703762M
Compliance #: HL338704209C

Date Concluded: October 14, 2024

Name, Address, and County of Licensee Investigated:
The Geneva Suites
6200 Parkwood Road
Edina, Minnesota 55436
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 the facility failed to complete perineal and catheter cares on the resident, resulting in multiple hospitalizations, urinary tract infections (UTI) and the resident lying in feces for multiple hours at a time.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The facility completed catheter care by emptying the catheter bag, and they addressed the resident's concerns when he had pain or other issues related to his catheter. Nursing worked with different home care agencies to assist the resident with other catheter needs outside the scope of the facility's services. However, the resident had multiple UTIs in a short period of time and stated these recurring UTIs while at the facility were due to staff not cleaning him. No evidence demonstrated the facility updated the resident's urologist after any of the UTIs, however there was evidence the facility provided updates to the resident primary care provider.

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigation included review of the resident record, home care records, hospital records, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed toileting and catheter care.

The resident resided in an assisted living facility. The resident's diagnoses included cerebral palsy and neurogenic bladder. The resident's service plan included assistance with emptying his catheter bag every shift as needed and bathing twice weekly. The resident's service plan indicated catheter changes were maintained by an outside nursing agency, and facility staff were to maintain catheter cleanliness and report concerns. The resident's assessment indicated the resident had a catheter, a history of UTIs, and needed assistance of two staff with bathing.

The resident resided at the facility approximately five months. The resident's admission assessment indicated the resident had been hospitalized for a UTI less than six months before his admission to the facility.

Over the course of about three months, several progress notes in the resident's record indicated the resident had continued concerns regarding his catheter and UTIs, including trips to the emergency department (ED) and hospitalizations.

Month one:
A progress note indicated the resident complained of a blockage in his catheter. The ULP reported he had urine flowing in the catheter. The resident received a dose baclofen (a medication used to alleviate muscle spasms) to help with bladder spasms. A second progress note thirty minutes later indicated the resident requested to go to the ED. A third progress note indicated the resident returned from the ED less than eight hours later. The resident had a UTI, and the hospital ordered antibiotics. A nurse notified the resident's provider.

Less than two weeks later, a progress note indicated the resident's catheter had not been draining properly. Although the nurse had been on her way to the facility to troubleshoot the catheter, the resident requested to go to the ED due to being in too much pain. A second progress note indicated the resident returned the same evening with orders for antibiotics.

Month two:
Less than one month later, a progress note indicated the resident complained of his catheter burning. Although a nurse was on the way to the facility to help, the resident called 911 and went to the ED. A second progress note indicated the resident returned a short time later without any new orders from the hospital.

Month three:
About one month later, a progress note in the resident's record indicated the resident spent less than twenty-four hours in the ED due to his catheter bypassing and not draining properly. Hospital staff changed the resident's catheter and tested him for a UTI. The hospital provider

diagnosed the resident with a UTI and started him on antibiotics. The progress note also indicated the resident planned to see a specialist regarding having a suprapubic catheter (a urinary catheter that enters the bladder directly through the abdomen, above the pubic bone) placed.

A progress note one week later indicated the resident went to the hospital and would be transferring to a transitional care unit (TCU) due to needing intravenous (IV) antibiotics every eight hours.

The resident returned to the facility a couple of weeks later. A progress note indicated the TCU facility's home care program would continue to follow him for catheter care.

A progress note one week later indicated the resident had pain and swelling in his testicle which he thought had been caused by the catheter the TCU placed. The note indicated the home care agency had been at the facility that same day and instructed the resident she would change it again soon. The facility nurse updated the resident's provider.

About two weeks later, a progress note indicated the resident admitted to the hospital and received IV antibiotics. A second progress note the same day indicated a nurse updated the resident's provider regarding the hospital admission and IV antibiotics.

Progress notes indicated the resident returned from the hospital two weeks later and discharged to another facility the next day.

Hospital records indicated the resident went to several different hospital systems' EDs for his urinary and catheter issue. The hospital records indicated they tried several different antibiotics, both orally and IV. The hospital records also indicated the resident had a history of UTIs. The records did not indicate these UTIs were due to lack of proper cleaning.

During an interview, nurse #1 stated the resident admitted with recurring UTIs. While onsite, the resident would come to her if he had any issues with his catheter which included bypassing, sediment in his tubing, or discomfort while urinating. When the resident arrived at the facility, he was supposed to be flushing his catheter himself. Nursing spent two weeks showing him how to do it, then they got a home care agency involved because he did not feel confident completing the task. Later, the home care agency discharged him because he started working. After a following hospitalization and subsequent TCU stay, a second home care agency worked with him after he returned to the facility. Nurse #1 stated staff cleaned the perineal area every morning.

During an interview, nurse #2 stated the resident requested having his catheter flushed twice daily, but that was outside the unlicensed personnel's scope and not something the facility would have delegated. Nurse #2 stated she supervised the staff but never observed staff completing his entire catheter care routine. Nurse #2 believed staff were completing the service

correctly and stated she supervised a lot there. Regarding showers, nurse #2 recalled two specific times he did not receive one. She addressed the issues with human resources.

During an interview, the resident's case manager stated the resident went to the emergency department frequently for UTIs. The case manager stated the staff were not cleaning the resident and catheter properly. The resident laid in urine all night once when his catheter bypassed. Despite using his call button, no one came to help him.

During an interview, the resident stated he had a history of UTIs caused by his catheter prior to residing at the facility. The resident always had to be hospitalized to receive IV antibiotics because nothing worked. The resident stated he also had a lot of UTIs while at the facility. Staff never cleaned him up, so he would keep getting infections. At night, facility staff checked on the resident but would not change him if he soiled his brief. Overnight staff told the resident they could not change him because they did not have a second staff person at night to help. The resident laid in a soiled brief until morning every night. Regarding showers, the resident stated he did not always get a shower on nights he returned to the facility late.

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, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility worked with home care agencies to ensure the resident received catheter care needs outside the scope of the facility.

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
	33870	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6200 PARKWOOD ROAD EDINA, MN 55436

(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: HL338704209C/HL338703762M On August 27, 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 four residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL338704209C/HL338703762M, tag identification 0470.	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.	
0 470 SS=E	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure sufficient staffing on the overnight shift to meet the scheduled and unscheduled needs of two of three residents (R1, R2). 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 a	0 470	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	

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0 470	Continued From page 2 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's diagnoses included cerebral palsy. R1's service plan dated July 1, 2024, indicated R1 received assistance of two staff with bathing and transfers using a mechanical lift, and assistance of one to two staff and the use of a trapeze bar for bed mobility. R1's assessment dated July 8, 2024, indicated R1 needed physical assistance of two to transfer and escort for evacuation in case of an emergency. R2's diagnoses included amyotrophic lateral sclerosis (ALS). R2's service plan dated September 18, 2024, indicated R2 received assistance with transfers and emergency evacuation. R2's assessment dated June 21, 2024, indicated R2 used a mechanical lift for transfers and electric wheelchair for mobility. The assessment also indicated R2 received physical assistance of two staff for transfers. The facility's staff schedule indicated only one staff person worked during the following times and days: September 1, 2024, from 12:00 a.m. to 6:05 a.m., 6:30 a.m. to 2:00 p.m., and 10:35 p.m. to 11:59 p.m. September 2, 2024, from 6:05 a.m. to 7:00 a.m., and 3:00 p.m. to 11:59 p.m. September 3, 2024, from 12:00 a.m. to 6:10 a.m., 6:35 a.m. to 7:00 a.m., 12:30 p.m. to 8:00 p.m., and 10:30 p.m. to 11:59 p.m.	0 470	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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0 470	Continued From page 3 September 4, 2024, from 12:00 a.m. to 6:05 a.m., 2:00 p.m. to 7:00 p.m., and 10:05 p.m. to 11:59 p.m. September 5, 2024, from 12:00 a.m. to 6:10 a.m., 6:25 a.m. to 7:00 a.m., 3:00 p.m. to 7:00 p.m., and 10:25 p.m. to 11: 59 p.m. September 6, 2024, from 12:00 a.m. to 1:50 p.m., 3:00 p.m. to 6:50 p.m., and 10:10 p.m. to 11:59 p.m. September 7, 2024, from 12:00 a.m. to 5:55 a.m. and 10:25 p.m. to 11:59 p.m. September 8, 2024, from 12:00 a.m. to 6:00 a.m., 3:15 p.m. to 7:00 p.m., and 10:15 p.m. to 11:59 p.m. September 9, 2024, from 12:00 a.m. to 6:15 a.m. and from 10:30 p.m. to 11:59 p.m. September 10, 2024, from 12:00 a.m. to 6:05 a.m. The staff scheduled indicated no staff were scheduled on September 2, 2024, from 1:50 a.m. to 6:05 a.m. During an interview on September 10, 2024, at 12:05 p.m., R1 stated staff at night would check on him, but they would not change him if he soiled himself due to having only one staff member working. During an interview on September 11, 2024, at 9:05 a.m., unlicensed personnel (ULP)-D stated only one staff member worked at night. If the overnight staff person needed help, they called someone to come to the facility. During an interview on September 17, 2024, at 10:03 a.m., licensed practical nurse (LPN)-A stated because the director of operations lived less than five minutes away, staff were to reach out to him to come to the licensee to assist as	0 470		

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0 470	Continued From page 4 needed. LPN-A stated because the residents did not need to get out of bed at night, the licensee did not need a second person on the overnight shift. The licensee-provided document titled Staffing Policy, dated April 30, 2024, indicated the purpose of the policy was to comply with the Minnesota Department of Health (MDH) by establishing a staffing plan to ensure compliance with two person assists within the facility. The policy ensured the facility remained in compliance with MDH at all times to meet resident needs and respond to emergencies or safety concerns. The policy also indicated the facility must have two ULPs available for residents requiring assistance from two individuals as outlined in the care plan for each shift. The second ULP provided additionally staffing to address scheduled and unforeseen resident needs. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		