*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL343213423M
**Compliance #:** HL343213622C

**Date Concluded:** October 14, 2024

**Name, Address, and County of Licensee Investigated:**
Geneva Suites
11416 Wild Hero Point
Eden Prairie MN 55347
Hennepin County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Maggie Regnier
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 a resident when it did not refill her medications for pulmonary arterial hypertension (PAH), Opsumit and Uptravi, for over one month resulting in the resident experiencing increased shortness of breath with normal activity.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was not substantiated. While it was true the resident did not receive one of her medications as prescribed for more than a month, the facility took steps to address the issue with the pharmacy and the medical provider.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted family members. The investigation included review of facility records, polices, staffing records, medical records and resident records.

The resident resided in an assisted living facility. The resident's diagnoses included dementia, liver cancer, PAH (a type of high blood pressure that affects the lungs and heart). The resident's medical record indicated she had both Opsumit and Uptravi prescribed for the treatment of PAH. The residents service plan indicated the PAH medications were to be ordered through a specialty pharmacy. This document included contact information for the specialty pharmacy.

A concern arose the facility had not administered the resident's Opsumit nor Uptravi for more than a month.

**Opsumit**
The resident's electronic medical record (EMAR) indicated the facility had administered the resident's Opsumit as prescribed during the time in question.

**Uptravi**
The EMAR indicated the unlicensed caregivers documenting it as intermittently "not available" three times over the course of seven days. On the eighth day, the EMAR indicated the facility initiated documenting Uptravi as "medication on order", which continued for approximately 37 days.

About two weeks after Uptravi had been marked as "on order", the progress notes indicated the facility contacted the specialty pharmacy regarding Uptravi. The progress notes indicated the pharmacy needed to contact the prescriber for adjusted doses. On the same day, the progress notes indicated the resident was seen by physical therapy which document "no acute concerns" although the resident had right knee pain. The same document indicated the resident tolerated the physical therapy well.

About three weeks later, the progress notes indicated the facility's inability to get Uptravi refilled due to need for prescriber orders and the need for prior authorization. The same document indicated the specialty pharmacy had been contacted multiple times. The note indicated the specialty pharmacy said the prior authorization was "finally approved" and would send the medication by mail. The same note indicated the resident's family was updated via email.

The EMAR indicated the facility began administering the Uptravi the next evening.

Approximately two weeks after the resumption of Uptravi, the resident was seen by a nurse practitioner who documented regarding PAH that the resident had no chest pain nor shortness of breath and her blood pressure remained stable.

**Interviews**
During an interview, a manager stated that during this time, the facility had an agency nurse who was the facility's director of nurses along with agency nurses working with the residents' ordering refills for residents as needed. The manager stated he was made aware of the

medication not being available for the resident but that he did not really oversee the clinical staff at that time.

During an interview, a family member stated that the resident was having symptoms that were affecting her quality of life and were related to the resident not getting the medication as ordered. The family member also stated the medications needed to be restarted at a low dose and increased slowly over time until they reached the therapeutic level prescribed by the doctor. The resident had been on these medications for a long time before this incident without and issues.

The investigation included attempts to interview the prescriber but was unsuccessful.

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 cognitive loss
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: Not Applicable

**Action taken by facility:**
The facility no longer has agency nurses in leadership roles. The facility now has one nurse review all medications to ensure medication refills are done in a timely manner.

**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 |
|---|---|---|---|
| | 34321 | A. BUILDING: _____ B. WING _____ | C 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GENEVA SUITES | 11416 WILD HERON POINT EDEN PRAIRIE, MN 55347 |

| (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<br><br>On September 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL343213622C/#HL343213423M. No correction orders are issued. | 0 000 | | |