Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343218746M
Compliance #: HL343216265C

Date Concluded: May 13, 2024

Name, Address, and County of Licensee Investigated:
The Geneva Suites
11416 Wild Heron Pl
Eden Prairie, MN 55347
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Danyell Eccleston, 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 gave too much narcotic pain medication to the resident which expedited the resident's death.

The alleged perpetrator, (AP), physically abused a resident when he forcefully shaved the resident's mustache.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect and abuse were inconclusive. The facility narcotic log, medication administration record, and pharmacy medication logs contain conflicting information making it unclear how much narcotic medication the resident received. The AP was working at the time of the incident and the resident's mustache was shaved; however, it could not be determined who shaved the resident's mustache.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted pharmacies that distributed medication for the resident, the police department, the resident's medical provider, and the hospice company. The investigation included review of medical records, pharmacy records, employee files, and policy and procedure. Also, the investigator observed staff members providing care at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included severe dementia and pelvic fractures. The resident's care plan included coordination of hospice care, medication management, and weekly shaving instructing assistive personnel to use electric razor to "trim" the resident's beard weekly.

Hospice medication orders indicated two days before the resident died, oxycodone (a narcotic for pain management) was increased to 10mg scheduled every four hours, and the day prior to the resident's death, oxycodone 10mg was ordered as needed every hour for pain and shortness of breath.

Pharmacy records from the day the resident admitted to the facility indicated oxycodone 5mg strength tablets were sent to the facility and the evening before the resident died indicated oxycodone 10mg strength tablets were sent to the facility.

The day the resident died, medication administration records (documentation that records when staff gave medications) indicated in a two-hour time span the resident received three separate administrations of 10mg of oxycodone, totaling 30mg and three separate administrations of 1mg of haloperidol, totaling 3mg. However, narcotic records (documentation that records the supply and amount of medication removed from supply for administration) from the time in question indicated staff members removed oxycodone on four separate occasions, one instance of 10mg removed and three instances of 20mg removed, totaling 70mg of oxycodone and narcotic records indicated no doses of haloperidol were removed from supply.

During interview, an unlicensed staff who worked during the time in question stated she was informed by a nurse the resident needed two tablets of medication to equal the correct dosage for the pain medication (oxycodone).

During interview, a nurse stated she had no concerns regarding the amount of pain medication given to the resident during end-of-life care.

During interview, the resident's family member stated the day the resident died, staff members gave the resident pain medication three times in the same hour.

Service delivery records indicated a staff member documented not completing shaving service for the resident four days before he died because the resident “fights very hard against all cares.”

Internal facility investigation indicated the resident’s family member requested the facility shave the resident’s face, but not the resident’s mustache. The investigation indicated the AP stated he used a razor purchased by the family member to shave the sides of the resident’s face, not the mustache.

During interview, the AP stated he attempted to shave the resident with the razor, but was unable to get the razor to work and did not shave the resident.

During interview, a family member stated the resident had a mustache his entire adult life and staff were told not to shave the resident’s mustache. The family member stated when he went to see the resident, the resident’s mustache was completely removed. The family member also stated the resident had an orbital razor which would have painfully ripped the hairs out when used to shave off the resident’s long mustache.

The resident death record indicated the cause of death was complications of pelvic fracture weeks after a fall.

In conclusion, the Minnesota Department of Health determined neglect and abuse were 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No, vulnerable adult deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted internal reviews of the incidents.

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
	34321	A. BUILDING: _____ B. WING _____	C 02/14/2024

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 ******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: #HL343216265C/#HL343218746M 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 6 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL343216265C/#HL343218746M, tag identification 1760, and 2160.	0 000		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760		

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01760	Continued From page 1 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) with records reviewed. 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 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). The findings include: The licensee failed to ensure the resident's medication, Oxycodone (a narcotic pain medication), and haloperidol (an antipsychotic medication) were administered as prescribed. R1's diagnoses included dementia and pelvic fractures. R1's service plan, dated August 29, 2023, indicated the resident received medication	01760		

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01760	Continued From page 2 management and administration services. R1's medication order, dated September 11, 2023, indicated Oxycodone 5mg was ordered to be given three times a day and every four hours as needed for pain. R1's medication order, dated September 12, 2023, indicated lorazepam 0.5mg was to be given as needed every four hours for anxiety and agitation. R1's medication order, dated September 15, 2023, indicated lorazepam 1mg was to be given three times daily and as needed every four hours for anxiety and agitation. R1's medication order, dated September 20, 2023, indicated Oxycodone 10mg was ordered to be given as needed every four hours for pain and shortness of breath. R1's medication orders, dated September 21, 2023, indicated Oxycodone 10mg was ordered to be given as needed every one hour for pain and shortness of breath and haloperidol 1mg was ordered every four hours and every hour as needed for agitation and anxiety. R1's individual narcotic record (document that records the supply and amount of medication removed from supply for administration), dated September 22, 2023, at 4:30 A.M., indicated two tablets of Oxycodone 10mg, totaling 20mg, were removed from R1's medication supply. R1's medication administration record (document that records when medications were given), dated September 22, 2023, at 4:00 A.M., indicated two tablets of Oxycodone 5mg, totaling 10mg, were	01760		

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01760	Continued From page 3 administered to R1. R1's individual narcotic record, dated September 22, 2023, at 8:00 A.M., indicated two tablets of Oxycodone 5mg, totaling 10mg, were removed from R1's medication supply. Another page of R1's individual narcotic record, dated September 22, 2023, at 8:00 A.M., indicated two tablets of Oxycodone 10mg, totaling 20mg, were removed from R1's medication supply. R1's medication administration record, dated September 22, 2023, at 8:00 A.M. indicated two tablets of Oxycodone 5mg, totaling 10mg, were administered to R1. R1's medication administration record, dated September 22, 2023, at 8:17 A.M., indicated two tablets of Oxycodone 5mg, totaling 10mg, were administered to R1. R1's individual narcotic record, dated September 22, 2023, at 9:45 A.M., indicated two tablets of Oxycodone 10mg, totaling 20mg, were removed from R1's medication supply. R1's individual narcotic record, dated September 22, 2023, at 10:15 A.M., indicated two tablets of Oxycodone 10mg, totaling 20mg, were removed from R1's medication supply. R1's medication administration record, dated September 22, 2023, at 10:02 A.M., indicated two tablets of Oxycodone 5mg, totaling 10mg, was administered to R1. R1's narcotic record for haloperidol indicated zero doses of the medication were removed from R1's medication supply. R1``s medication administration record, dated September 22, 2023, at 12:00 A.M., 4:00 A.M., 8:17 A.M., and 10:02 A.M. indicated 1 tablet of	01760		

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01760	Continued From page 4 haloperidol 1mg was administered to R1. During interview on February 14, 2024, at 12:42 P.M, unlicensed personnel (ULP) - A stated she administered medication to R1` and was told by a nurse that the resident needed to receive two tablets of Oxycodone when receiving the medication. During interview on February 14, 2024, at 1:04 P.M., the licensed assisted living director (LALD)-A stated R1 had two different tablet dosages of Oxycodone while he was at the facility and believed R1 only received the allotted amounts of Oxycodone. During interview on March 1, 2024, at 2:15 P.M., a family member (FM)-1 stated on the day R1 died staff gave pain medication to R1 three times in the same hour. FM-1 stated a staff member at the facility sent him a copy of R1's narcotic log that showed staff members signing out narcotics for the resident. During interview on March 12, 2024, at 3:09 P.M., ULP-C stated she believed there were narcotic errors regarding R1's medication and R1's records made it appear that he received too much narcotic medication. Review of document titled Table of Contents - The Geneva Suites Policy Manual, undated, indicated "Narcotic Management, Control, and Disposition - No policy." TIME PERIOD FOR CORRECTION: Fourteen (14) days	01760		

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02160	Continued From page 5	02160		
02160 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident dignity and choices for meaningful engagement with other facility residents for one of one residents (R1) who resided in the Assisted Living unit. The licensee failed to provide person-centered care that promoted resident dignity after the resident's mustache was shaved off while he resided at the licensee.	02160		

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02160	Continued From page 6 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 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 diagnoses included dementia and pelvic fractures. R1's service plan, dated 9/11/2023, indicated staff would use an electric razor to "trim" resident's beard weekly. Facility internal investigation, dated 9/22/2023, indicated R1's family member (FM)-1 was upset because someone shaved R1's mustache. The investigation indicated R1 had a full mustache and beard on 9/16/2023 and on 9/21/2023 staff noted R1's facial hair was completely shaved off. Photographs of R1 throughout his adulthood showed R1 with a mustache. Photograh, undated, showed the resident sitting in the common area with a mustache. Photograph, dated September 20, 2023, showed R1 to no longer have a mustache. On March 1, 2024, at 2:15 p.m., family member (FM)-1 stated he spoke with staff to ensure R1's mustache would not be shaved and provided an orbital razor to the facility for shaving R1's beard. FM-1 stated when he went to see R1, he no longer had a mustache and was informed a staff member removed R1's mustache. FM-1 stated	02160		

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02160	Continued From page 7 R1 had a mustache his entire life and using an orbital shaver would have ripped the hairs out. On March 14, 2024, at 9:40 A.M., an unlicensed personnel (ULP)-1 stated he attempted to trim R1's beard with the orbital shaver, but it did not work. ULP-1 stated FM-1 indicated he would shave R1, and FM-1 shaved the resident. Minnesota Assisted Living Resident Bill of Rights, dated August 12, 2022, indicated residents have the right to be treated with courtesy and respect. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02160		