Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326995002M
Compliance #: HL326991267C

Date Concluded: December 15, 2025

Name, Address, and County of Licensee Investigated:
The Geneva Suites
1599 Blackhawk Lake Drive
Eagan, MN 55122
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: James Larson, 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 services were not provided in accordance with the resident's service plan, resulting in meals getting missed, wounds, missed medications and multiple hospitalizations.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did have wounds and was hospitalized, the resident's service plan and facility policies and procedures were followed. The facility staff and outside agency worked together to monitor and continually assess the wounds for further injury. The other allegations were investigated and did not rise to the level of neglect.

The investigator conducted interviews with facility nursing staff and contacted a family member. The investigation included review of the resident's records, facility internal documentation, as well as related facility policies and procedures. The investigator toured the

facility, observed staff interacting with residents and completing scheduled care activities at the time of the onsite visit.

The resident resided in an assisted living facility. The resident's diagnoses included Dysphagia (difficulty swallowing), respiratory failure, kidney transplant. The resident's service plan included assistance with all activities of daily living, housekeeping, laundry as well as scheduled incontinence care and repositioning checks. The resident's assessment indicated that the resident has difficulty communicating his needs. The resident is at risk of dehydration and aspiration requiring staff to offer a soft diet and thickened liquids. The resident requires assistants for all movements and was bedbound.

A review of the resident's medical records indicated that resident had a history of kidney transplant and requires the use of an indwelling catheter (a device to collect urine). Prior to the resident admitting to the facility, the resident had been hospitalized to treat a urinary tract infection.

Medical records indicated while conducting a skin assessment facility staff observed a wound on the resident's coccyx (tail bone area) described as 2 centimeters (cm) by 1 cm. Days later, other wounds were identified on both heels. The facility contacted the home care agency as well as the residents primary care provider. In addition, the facility reinforced staff education on repositioning and offloading the pressure on these bony prominences. Later that week the resident presented with a fever and was transported to a local hospital for treatment of another urinary tract infection. Upon returning to the facility, facility staff noted that the wound on the resident's coccyx area had progressed and gotten larger. Days later the resident complained of pain and was again transported to a local hospital for pain management and wound treatment. During the month new interventions were implemented including a geriatric bed, air mattresses, new chair cushion and wheelchair head rest.

Hospital records from the last hospitalization indicated the provider documented the resident's wound had been treated however it had increased in pain and had new drainage over the past four weeks. The resident was discharged from the hospital to a higher level of care.

During an interview, a nurse stated that a week after being admitted to the facility staff observed a sore had appeared on the resident's coccyx (tailbone area) and then days later his heels as well. The home care team was notified of these findings, the facility care plan was updated and staff received reinforcement education on repositioning and pressure alleviating techniques. The nurse voiced concerns to the care team, and the family over the acuity of care being needed, as well as the worsening condition of the resident's wounds and lack of healing. The facility made attempts to have additional medical equipment provided as well as having a different agency care for the wounds but due to insurance restrictions it was not possible.

During an interview, a nurse from another agency assigned to the residents wound care stated that a care plan was in place to treat the resident three times a week, although due to the

number of hospitalizations, this frequency was not made possible. The resident was only able to receive wound care on one occasion prior to being discharged from the service.

During an interview a family member stated that there were occasions she witnessed inconsistencies in the timing of certain services being offered to the resident, relating to food service and repositioning, as well as the facility being aware of an issue with the resident's bed not functioning fully. She went on to state that the facility nursing staff was involved in collaboration concerning wound care with the entire care team. After multiple hospitalizations the family chose to relocate the resident to a higher level of care facility out of state.

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, unavailable.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility nursing staff continued to assess the residents needs and contacted the residents primary care provider on more than one occasion to re-assess the need for updated care orders.

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
	32699	A. BUILDING: _____ B. WING _____	C 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	1599 BLACKHAWK LAKE DRIVE EAGAN, MN 55122

(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 November 17, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL326991267C/#HL326995002M. No correction orders are issued.	0 000		