Electronically Delivered

October 23, 2026

Licensee
The Geneva Suites
9145 Meadowview Road
Bloomington, MN 55425

RE: Project Number(s) SL32258016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 23, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32258	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	9145 MEADOWVIEW ROAD BLOOMINGTON, MN 55425

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32258016-0 On September 21, 2026, through September 23, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license.	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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 is 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). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 22, 2026, for the specific Minnesota Food Code violations. The	0 480		

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0 480	Continued From page 3 Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the licensee's grievance procedure, with the current name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a	0 550		

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0 550	Continued From page 4 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 is 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). The findings include: During a facility tour on September 21, 2026, at 11:05 a.m., the surveyor observed the facility postings and a grievance form located in the main entrance of the facility with owner/licensed assisted living director (O/LALD)-A. The grievance posting included a nurse that was no longer employed by the licensee. The grievance form lacked the current contact information including the name, email, and phone number for the individual responsible for handling resident grievances. On September 21, 2026, at 11:10 a.m., O/LALD-A stated she realized the contact information on the posted grievance procedure was the licensee's previous nurse and the posting needed to be updated. The licensee's 2.09 Complaint/Grievance policy revised June 1, 2026, indicated, "Complaints that cannot be easily resolved or have not been resolved to an employee or resident's satisfaction should be dealt with in the following way: 1. A facility complaint form should be filled out by the resident, resident representative, or employee and given to the supervisor of the department or to the Assisted Living Director. 2. If a resident, resident representative, or employee cannot, for any reason, fill out a	0 550		

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0 550	Continued From page 5 complaint form one will be completed on their behalf by the supervisor or Assisted Living Director. 3. When possible and reasonable, the complaint will be resolved immediately involving others as needed. 4. If needed, an investigation surrounding the facts of the complaint shall be initiated. 5. During the investigation process, and when possible, residents, resident representatives, or employees will be asked to participate in determining the solution and bring about resolution of the complaint. 6. After an investigation is complete, a prompt response to the resident, resident representative, or employee complaint or concern will be provided verbally and, if desired, in writing. Residents or employees will be given a reasonable explanation for the action taken on their behalf. 7. In a case where maltreatment was identified (abuse, neglect, or exploitation), a staff of [Licensee] will promptly contact the Minnesota Adult Abuse Reporting Center (MAARC) to make a report. 8. If the resolution of a complaint results in a system or procedure change, the change shall be made and communicated appropriately to employees or residents, keeping the confidentiality in mind. 9. Finalized resident complaints will be kept in the resident record. Finalized employee complaints will be kept for five years then disposed of. " No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 660	Continued From page 6	0 660		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) completed within 90 days of hire date for one of three employees (clinical nurse supervisor (CNS)-B). 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	0 660		

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0 660	Continued From page 7 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's TB Facility Risk Assessment worksheet, dated June 18, 2026, indicated the facility was at low risk for TB transmission. CNS-B was hired December 8, 2025, to provide direct nursing care and supervision for the licensee's residents. On September 21, 2026, at a.m., the surveyor observed CNS-B assist unlicensed personnel (ULP)-D with medication administration for R1. CNS-B's employee record included an Employee Tuberculosis (TB) Screening Questionnaire dated June 4, 2026 (6 months after hire), and negative TB QuantiFERON Gold test dated May 19, 2025, completed more than 90 days before hire date. On September 1, 2026, at 8:50 a.m., CNS-B stated she could not find another TB test completed within 90 days prior to her hire date. CNS-B stated the licensee's human resource department thought the required time frame for an employee's TB screening test was to be completed within six months of hire date. The licensee's 8.16 Tuberculosis Screening policy revised June 1, 2026, indicated, "The [Licensee] will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis	0 660		

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0 660	Continued From page 8 Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR)." In addition, included, "Staff whose essential job functions require work within the same air space of residents will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure." The CDC's Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC dated May 16, 2019, recommended all health care professionals complete a TB screening including a symptom evaluation and an IGRA or TST. Health care workers with written documentation of a previous positive TST or IGRA should have documented in their record: test results, assessment for current TB symptoms and a related chest x-ray. The Minnesota Department of Health (MDH) Regulations for TB Control in Minnesota Health Care Settings, dated July 2013, indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 800		

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0 800	Continued From page 10 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 22, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	01290		

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	32258	A. BUILDING: _____ B. WING _____	09/23/2026

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01290	Continued From page 12 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study affiliated with the licensee's health facility identification number (HFID), upon hire, and prior to providing services, for one of eighteen employees (unlicensed personnel (ULP)-F). 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's HFID was 32258, and the licensee provided assisted living services beginning August 1, 2021. ULP-F was hired August 16, 2022, and provided direct assisted living cares to the licensee's	01290		

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01290	Continued From page 13 residents. ULP-F's employee record included a cleared background study dated August 9, 2019, affiliated with HFID 32475, an office location owned by the licensee. ULP-F's record lacked evidence of a cleared background study affiliated with the licensee's HFID 32258. On September 22, 2026, at 10:15 a.m., the licensee's DHS NETStudy 2.0 employee background study roster was reviewed with director of operations (DO)-C and clinical nurse supervisor (CNS)-B. CNS-B stated ULP-F was a current full-time caregiver for the licensee and worked the evening shift. CNS-B stated she was told by her human resource department that ULP-F was not currently affiliated with the current license, HFID 32258. CNS-B verbalized the licensee was in the process of updating ULP-F's background study. On September 23, 2026, at 2:20 p.m., owner/licensed assisted living director (O/LALD)-A provided, via email, the surveyor with a background study clearance letter for ULP-F, dated September 23, 2026, affiliated correctly to the current facility, HFID 32258. The new background study was completed during the time of survey. The licensee's 4.02 Background Studies policy, revised June 11, 2026, indicated "[Licensee] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [Licensee]. No employee may provide direct services and have independent direct contact with any residents until an acceptable result of the background study have been received. [Licensee] will not employ	01290		

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01290	Continued From page 14 individuals whose results of the background study indicate disqualification for the position." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for	01370		

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01370	Continued From page 15 the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competencies required for all unlicensed personnel (ULP) were completed with all required content for one of two employees (ULP-D). 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: On September 21, 2026, at 10:27 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated initial training, and competency was completed by the licensee's nurse. Also, CNS-B verbalized the licensee's orientation, and training was completed both in person and utilizing an online training program. ULP-D was hired March 16, 2026, to provide	01370		

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01370	Continued From page 16 direct care services to the licensee's residents. On September 21, 2026, at 11:47 a.m., the surveyor observed ULP-D assist R1 with medication administration. The licensee's staff scheduled September 21, 2026, to September 26, 2026, indicated ULP-D worked three days per week, eight-hour shifts on the day shift from 6:00 a.m., to 2:00 p.m. ULP-D's employee record lacked documentation of training and competency evaluations including: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -understanding appropriate boundaries between staff and residents and the resident's family; and -awareness of commonly used health technology equipment and assistive devices. On September 23, 2026, at 9:58 a.m., CNS-B stated ULP-D appeared to be missing some core training and competencies as required but she would check one other location to see if she could find documentation of the training. On September 23, 2026, at 11:40 a.m., CNS-B confirmed there was no additional training documentation found for ULP-D so there were some required training topics that were not yet completed or documented. The licensee's 4.18 Employee General Orientation policy, revised June 11, 2026,	01370		

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01370	Continued From page 17 indicated, "Upon hire and prior to performing any functions of their position at [Licensee], each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure competency evaluations required for unlicensed personnel (ULP) providing assisted living services were completed for one of two employees (ULP-D).	01380		

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01380	Continued From page 18 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: On September 21, 2026, at 10:27 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated initial training, and competency was completed by the licensee's nurse. Also, CNS-B verbalized the licensee's orientation, and training was completed both in person and utilizing an online training program. ULP-D was hired March 16, 2026, to provide direct care services to the licensee's residents. On September 21, 2026, at 11:47 a.m., the surveyor observed ULP-D assist R1 with medication administration. ULP-D's employee file lacked documentation of competency evaluations for the following topics: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. On September 23, 2026, at 9:58 a.m., CNS-B	01380		

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01380	Continued From page 19 stated ULP-D appeared to be missing some core training and competencies as required but she would check one other location to see if she could find documentation of the training. On September 23, 2026, at 11:40 a.m., CNS-B confirmed there was no additional training documentation found for ULP-D so there were some required training topics that were not yet completed or documented. The licensee's 4.18 Employee General Orientation policy, revised June 11, 2026, indicated, "Upon hire and prior to performing any functions of their position at [Licensee], each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one	01530		

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01530	Continued From page 20 hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required dementia care training and two hours of initial mental illness and de-escalation training were conducted within 160 working hours of the employment start date for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a	01530		

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01530	Continued From page 21 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: ULP-D was hired March 16, 2026, to provide direct care services to the licensee's residents. On September 21, 2026, at 11:47 a.m., the surveyor observed ULP-D assist R1 with medication administration. ULP-D's employee record lacked documentation she completed the required eight hours of initial dementia care training and two hours of initial training on mental illness and de-escalation topics within 160 hours of start date. The licensee's staff schedule dated September 21, 2026, to September 26, 2026, indicated ULP-D worked three days per week, eight-hour shifts on the day shift from 6:00 a.m., to 2:00 p.m. On September 23, 2026, at 9:58 a.m., CNS-B stated ULP-D had not yet completed the eight hours of dementia training and two hours of mental health with de-escalation training. The licensee's 5.03 Dementia Training policy revised June 1, 2026, indicated, "2. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. 3. Employees may not provide direct care until the training is complete unless another	01530		

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01530	Continued From page 22 employee who has completed the initial training is present to provide assistance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620		

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01620	Continued From page 23 Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted resident monitoring and reassessment including a reassessment completed within 14 days after the initiation of services for one of two residents (R1). 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).	01620		

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01620	Continued From page 24 The findings include: On September 21, 2026, at 10:27 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the nurse performed resident assessments at admission, within 14 days of admission, every 90 days, and with any resident changes in condition. R1 was admitted on July 30, 2025, after being discharged from another facility owned by the licensee. R1 had diagnoses including progressive supranuclear palsy with ophthalmoplegia (a rare neurological disorder that affects body movements, walking and balance, and eye movements), Parkinsonism (an umbrella term for a neurological syndrome defined by core movement symptoms, including muscle stiffness, slowed movement, tremors, and balance problems), and hypertension (high blood pressure). R1's signed service plan, dated July 28, 2025, indicated R1 received services including assistance with housekeeping, meals, laundry, bathing, grooming, dressing, continence cares, skin care, positioning and transfers, therapeutic exercises, walking, wheeling, socialization, and medication administration. On September 21, 2026, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R1 with medication administration. R1's medical record included an initial assessment dated July 28, 2025, two days before admission to the facility, and lacked a subsequent 14-day reassessment completed within 14 days	01620		

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01620	Continued From page 25 after start of services. On September 22, 2026, at 9:29 a.m., CNS-B stated she was not aware a new admission assessment was required when a resident moved from one facility to another facility with different health facility identification numbers (HFIDs) owned by the same licensee. Education provided. CNS-B verbalized there was not a new admission assessment or 14-day assessment completed for R1 when he transferred to the current facility on July 30, 2025. The licensee's 6.01 Assessments, Reviews & Monitoring policy revised June 10, 2026, indicated, "3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32258	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	9145 MEADOWVIEW ROAD BLOOMINGTON, MN 55425

(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
01640	Continued From page 26 service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for three of four residents (R3, R4, R5). 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). The findings include: R3 R3 was admitted on January 15, 2020, and had diagnoses including traumatic brain injury, depression, chronic pain, and peripheral vascular	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32258	A. BUILDING: _____ B. WING _____	09/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 27 disease (narrowed arteries reduce blood flow to the arms or legs). R3's signed Service Plan dated June 11, 2025, indicated R3 received services including assistance with housekeeping, meals, laundry, bathing, grooming, dressing, continence cares, transportation, insulin (resident was not receiving insulin administration), skin care, positioning, transfers, therapeutic exercises, walking, socialization, treatments as ordered by provider, and medication administration. R3's Department of Human Services (DHS) Support Plan (SP) dated November 1, 2025, through October 31, 2026, indicated R3's services authorized included housekeeping and laundry 1.5 units/day, money management 2 units/month, breakfast 1 unit/day, lunch 1 unit/day, supper 1 unit/day, snack 2 units/day, individual staff ratio 1:1, 3 units/day, individual staff ratio 1:2-5, 2 units/day, dressing .5 unit/day, grooming .5 unit/day, bathing 2 units/week, continence care 2 units/day, positioning .25 units/day, walking 1 unit/day, wheeling .15 unit/day, transferring .5 unit/day, assistance with self-administration of medication 1 unit/day, therapeutic exercises .75 unit/day, delegated clinical monitoring .28 unit/day, other delegated tasks 1 unit/day, medication setups and monitoring .43 unit/day, managing orientation issues 2 units/day, managing repetitive behavior 3 units/day, managing agitation .5 unit/day, and managing verbal aggression .5 unit/day. R3's documentation of services provided dated September 1, 2026, through September 22, 2026, lacked documentation the licensee provided the following: -staff 1:1 ratio or 1:2 - 1:5 ratio,	01640		

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01640	Continued From page 28 -positioning .25 units/day, -walking 1 unit/day, and -therapeutic exercise .75 unit/day. R3's service plan lacked 1:1 staff ratio, 1:2 to 5 staff ratio, and behavior management interventions which were noted to be authorized in R3's DHS SP. In addition, R3's service plan included positioning, transfers, and insulin services. Clinical nurse supervisor (CNS)-B stated R3 was not receiving assistance with these services. On September 23, 2026, at 9:33 a.m., CNS-B stated R3 was not receiving assistance with positioning, transfers, and walking, as R3 was able to move and transfer independently and used his walker independently. CNS-B further stated she was not sure why insulin was included on R3's service plan as he did not receive insulin administration from the licensee. CNS-B stated there must have been an error when R3's service plan was corrected. CNS-B further stated she was not sure why behavior management was not included in R3's service plan because the staff currently provided assistance with behavior management for R3. CNS-B stated she planned to revise R3's service plan to ensure the services were accurate, and provided based on assessed resident needs and aligned with the DHS support plan. R4 R4 was admitted on April 25, 2024, and had diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a stroke with left-sided body weakness), heart failure, major depressive disorder and mild cognitive impairment.	01640		

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01640	Continued From page 29 R4's Service Plan dated April 29, 2024, indicated R4 received services including assistance with bathing weekly and as needed, mobility assist of one once daily and treatments as prescribed by doctor. The service plan lacked individual or group staff ratios and lacked behavior interventions. R4's Department of Human Services (DHS) Support Plan (SP) dated August 1, 2026, through July 31, 2027, indicated the services authorized included staff 1:1 ratio of 1 unit/day (15 minutes), staff 1:2 to 1:5 ratio of 2 units/day (30 minutes), bathing 0.5 units/day (7.5 minutes), walking 0.75 units/day (11.25 minutes), repetitive behavior interventions 0.5 units/day (7.5 minutes), agitation 0.5 units/day (7.5 minutes), and verbal aggression 0.25 unit/day (3.35 minutes). R4's documentation of services provided dated August 1, 2026, through August 31, 2026; and September 1, 2026, through September 22, 2026, lacked documentation the licensee provided the following: -staff 1:1 ratio or 1:2 to 1:5 ratio, or individual or small group activities; -bathing daily as indicated on the DHS SP (bathing was provided once weekly), -behavioral interventions for agitation or verbal aggression. In addition, walking was documented as provided daily, however staff interview and observations indicated R4 no longer walked. R4's physical therapy (PT) progress notes dated July 21, 2026, through September 18, 2026, lacked documentation that R4 walked. On September 21, 2026, through September 22, 2026, throughout the survey, the surveyor	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32258	A. BUILDING: _____ B. WING _____	09/23/2026

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01640	Continued From page 30 observed R4 would self-propel her wheelchair using her right arm and right leg instead of walking. R4 had her left arm in a sling, and her left foot had a pressure reducing boot on. On September 22, 2026, at 10:36 a.m., R4 stated staff assisted with bathing once per week, not daily as identified on her service plan. R4 was not sure if she received individual staff ratio times or 1:2 to 1:5 ratio times. R4 also stated she no longer walked and stated her mood was stable. On September 22, 2026, at 11:25 a.m., unlicensed personnel (ULP)-D stated she worked with R4 routinely for about the last six months and was familiar with R4's cares. ULP-D stated R4 was not walking, and staff would assist her with a pivot transfer from bed to wheelchair, and from there R4 could self-propel her wheelchair. ULP-D stated R4 had some agitation when a former resident resided in the facility but it was not a daily occurrence. ULP-D stated the former resident had not been in the facility for around one and a half months. R5 R5 was admitted on September 17, 2024, and had diagnoses of Alzheimer's disease with early onset and encephalopathy (altered brain function). R5's Service Plan dated April 1, 2025, indicated R5 received assistance with transportation (notify family of medical appointments, arrange transportation and escort) as needed, positioning and transfers (assist with transfers and repositioning in bed, chair, toileting, etc.) daily and as needed, walking (encouragement and/or assistance; monitor abilities, standby assist as needed, reminders to use walker, cane, etc.) daily	01640		

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01640	Continued From page 31 and as needed, socialization (group and individual; encourage discussions, reading, movies, games, music, etc.) daily and as needed, and any treatments as doctor ordered daily and as needed. R5's Department of Human Services (DHS) Support Plan (SP) dated February 1, 2026, through January 31, 2027, indicated the services authorized included assistance making appointments 1 unit/month (15 minutes), staff 1:1 ratio of 2 unit/day (30 minutes), staff 1:2 to 1:5 ratio of 3 units/day (45 minutes), transfers 0.5 units/day (7.5 minutes), agitation interventions 0.5 units/day (7.5 minutes), and sexual inappropriateness interventions 0.5 units/day (7.5 minutes). R5's documentation of services provided dated August 1, 2026, through August 31, 2026; and September 1, 2026, through September 22, 2026, lacked documentation the licensee provided the following: -staff 1:1 ratio or 1:2 to 1:5 ratio, -behavioral interventions for agitation or sexual inappropriateness, and -assistance with appointments. Ambulation was documented as provided daily, however staff interview and observations indicated R5 walked independently. On September 21, 2026, through September 22, 2026, throughout the survey, the surveyor observed R5 walked independently in the house and outside, including stairs in the backyard and uneven ground. No behaviors were observed. R5 was uncomfortable being interviewed and declined to have a conversation about services. On September 22, 2026, at 11:25 a.m., ULP-D	01640		

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01640	Continued From page 32 stated she worked with R5 routinely for about the last six months and was familiar with R5's cares. ULP-D stated R5 sometimes needed redirection for wandering as a behavior, but ULP-E had not noticed any agitation or sexual inappropriateness. ULP-E also stated R5 could ambulate independently inside and outside. On September 23, 2026, at 12:45 p.m., owner/licensed assisted living director (O/LALD)-A stated they compared the licensee's care plans to the DHS SP instead of the licensee's service plans to the DHS SP and would need to revise their process to ensure accuracy. CNS-B verified there was no documentation of resident behaviors or interventions. The licensee's 6.10 Service Plan Modification policy revised June 1, 2026, indicated, "PROCEDURE: If the service plan needs to be modified due to a change in a prescriber's order or a change in the resident's needs, the Service Plan Modification form will be completed; this form includes: -Describe changes in service and whether the service is added (new), changed, or discontinued -Frequency of new service or if service if terminated -Identification of the staff who will perform the service -Schedule and methods of monitoring staff -Date/Signature of RN making changes -Date/ signature of resident or the resident's representative each time a modification is made. The signature may be obtained by electronic signature, mail or fax if an agreement was reached in person or by telephone." No further information was provided.	01640		

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01640	Continued From page 33 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled;	01790		

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01790	Continued From page 34 (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained the unlicensed staff and determined the unlicensed staff was competent to follow the procedures for giving medications to residents during unplanned times away as required for one of two unlicensed personnel (ULP-E). 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	01790		

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01790	Continued From page 35 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: ULP-E was hired on June 23, 2025, to provide direct care services to the licensee's residents. ULP-E's record lacked evidence of training on procedures for preparing medications for an unplanned time away. On September 23, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated the medication management training program in the licensee's training log did not include documentation of the medication preparation for resident's leave of absence, unplanned time away. CNS-B stated they do prepare medications for residents with unplanned time away, and she teaches the process with the licensee's employees, but it was not documented for ULP-E. The licensee's 5.10 Training Records policy revised June 11, 2026, indicated, "The [Licensee] will maintain a record of staff training and competency required." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

THE GENEVA SUITES
9145 MEADOWVIEW ROAD
Bloomington, MN 55425
Hennepin County
Parcel:

Phone:
luis.b@thegenevasuites.com; Aimee.G@thegenevasuites.com

License Info

License: HFID 32258

Risk:
License:
Expires on:
CFPM: Marlena Hemenway
CFPM #: 34104; Exp: 3/23/2029

Inspection Info

Report Number: F8044261363
Inspection Type: Full - Single
Date: 9/22/2026 Time: 10:18:50 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: Signs not posted at handwashing sink in kitchen or bathroom.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: Signet Neutral disinfectant used on counters is not approved for food contact surfaces.
Comply By: 9/22/2026 Originally Issued On: 9/22/2026

Food & Beverage General Comment

HRD inspection conducted with nurse evaluators Dede Hinnendael and Sara Freking. Inspection report reviewed on site with Leslie Kemp.

Domestic kitchen consists of tiled floors, tiled walls, painted ceilings, wooden hollow base cabinets, solid surface counters, and domestic equipment.

Meals are prepared offsite in a licensed kitchen owned by The Geneva Suites.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F8044261363 from 9/22/2026

Establishment Representative

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

THE GENEVA SUITES
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F8044261363
Inspection Type: Full
Date: 9/22/2026
Time: 10:18:50 AM

Food Temperature: Product/Item/Unit: Barley soup**; Temperature Process:** Cold-Holding
Location: Refrigerator at 37.8 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Refrigerator at 34.0 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Ave NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

THE GENEVA SUITES
Bloomington
County/Group: Hennepin County

Inspection Info

Report Number: F8044261363
Inspection Type: Full
Date: 9/22/2026
Time: 10:18:50 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL32258016-0	**Date:** September 22, 2026
Facility Name: THE GENEVA SUITES	
Facility Address: 9145 MEADOWVIEW RD, Bloomington, MN, 55425	

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: The exterior window molding of the sunroom had a section of wood missing.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor observed the evacuation plans lacked accurate identification of resident rooms. Exit plan diagrams must be correctly labeled and accurate to the layout of the facility to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The facility used an electronic care plan website and paper documents for standard resident evacuation procedures. Resident specific needs were not identified in the electronic record; The paper documents did identify specific resident needs but used color coding to identify the resident which didn't match any other documentation. The paper documents also stated for the resident in bedroom 5 to exit out of their exterior bedroom door and go to the assembly area at the end of the driveway. The resident in bedroom five used a wheelchair for mobility, there was not a path or accessible route for the resident to take that would allow them to meet at the assembly area.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: The director of operations (DO)-C failed to provide any record of staff training on the FSEP. Staff should be trained on the FSEP upon hire and at least twice a year thereafter.

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: DO-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.