Electronically Delivered

December 1, 2021

Administrator
Keystone Bluffs
2528 Trinity Road
Duluth, MN 55811

RE: Project Number(s) SL29456015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 3, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. 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 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 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 the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

85 East Seventh Place
St. Paul, MN 55164-0970

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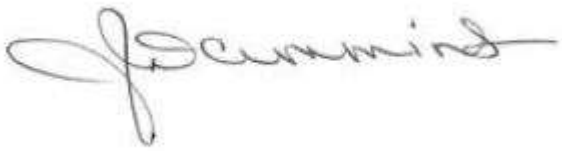
You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jeri Cummins, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-302-6193 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE BLUFFS	2528 TRINITY ROAD DULUTH, MN 55811

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#29456015 On, November 1, 2021 through November 3, 2021 surveyors of this Department's staff, visited the above provider and the following correction orders were issued. At the time of the survey, there was 84 residents that were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' 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 subd. 1, 2 and 3	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan included all the required components. This had the potential to affect all 84 residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety),and was issued at a widespread scope (when problems are pervasive	0 470		

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0 470	Continued From page 2 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: On November 1, 2021, at approximately 12:30 p.m. licensed assisted living director (LALD)-A stated the licensee had a staffing plan and stated the staffing plan was posted outside of the LALD-A's office by the main entry. The licensee's posted Director of Nursing Staffing Module, undated, indicated the staffing breakdown was based on the number of current residents the licensee was providing services to and the number of staff that are working. The licensee's Director of Nursing Staffing Module lacked evidence the staffing level was based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract; and -each resident's acuity level, as determined by the most recent assessment or individualized review. The licensee's [facility name] Director of Nursing Staffing Module did not include an evaluation of staffing levels in the facility. On November 2, 2021, at approximately 2:15 p.m. LALD-A confirmed the staffing plan was based on the current census. LALD-A stated the ratio of staff to residents is based on the number of staff and does not reflect the equity of the residents. No further information was provided.	0 470		

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0 470	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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 had the potential to affect the licensee's 84 residents receiving assisted living services. 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	0 480		

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0 480	Continued From page 4 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated October 5, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all 84 residents receiving assisted living services.	0 580		

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0 580	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a 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: On November 1, 2021, at approximately 1:30 p.m., during the entrance conference with the licensed assisted living director (LALD)-A, a request was made to review documentation of the licensee's quality management activities. LALD-A confirmed the licensee had not formalized or had documentation of ongoing quality management activities relevant to the size and services provided by the assisted living. The licensee's 1.47 - Quality Management policy revised October 29, 2021, indicated the licensee shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. Documentation about Quality Management activity must be available for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 6 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included a background study for one of four employees (unlicensed personnel (ULP)-I; included a license for one of one (licensed practical nurse (LPN)-G; and included a job description for one of four employees (ULP-J) with records reviewed.	0 650		

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0 650	Continued From page 7 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: ULP-I's employee record lacked documentation of a background study. ULP-I was hired on August 1, 2021, to provide direct care services to residents of the facility. On November 2, 2021, at approximately 7:51 a.m. ULP-I was observed assisting resident (R) 5 with morning cares and transferring. On November 3, 2021, at approximately 10:15 a.m. administrative coordinator (AD)-K confirmed ULP-I's record lacked documentation of a background study. AD-K stated she could print out another copy of ULP-I's background study. LPN-G's employee record lacked documentation of a current LPN license. LPN-G was hired on August 1, 2021, to provide direct care services to residents of the facility. On November 2, 2021, at approximately 8:00 a.m., LPN-G was observed to conduct a blood glucose check and administer insulin to R2. At approximately 1:10 p.m., LPN-G was observed to provide wound care for R2. On November 3, 2021, at approximately 10:05 a.m., the AD-K verified LPN-G's employee record did not include a copy of her current LPN license.	0 650		

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0 650	Continued From page 8 AD-K later provided a copy of LPN-G's current LPN license that expires on August 31, 2023. ULP-J's employee record lacked evidence of a current job description which included the qualifications for the position, responsibilities, and identification of staff providing supervision. ULP-J was hired on September 7, 2021, to provide direct care services to residents of the facility. On November 3, 2021, at approximately 10:00 a.m., AD-K confirmed ULP-J's employee record lacked a current job description. On November 3, 2021, at approximately 10:25 a.m., licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding content of employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 9 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all 84 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a 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 the entrance conference on November 1, 2021, at approximately 12:30 p.m. the surveyor	0 680		

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0 680	Continued From page 10 requested to view the licensee's emergency preparedness plan. Licensed assisted living director (LALD)-A provided a copy of the licensee's emergency preparedness plan for review. The licensee's emergency preparedness plan lacked a communication plan that included: - arrangement with other facilities. - names and contact information for staff, resident physicians, other facilities. - contact information for federal, state, tribal, local EP staff, ombudsman. - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies. - a method of sharing information and medical documentation for residents. - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy and -a method of sharing information from the emergency plan with residents and their families. On November 2, 2021, at approximately 2:15 p.m. LALD-A confirmed the licensee's emergency preparedness plan lacked a communication plan as indicated above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 11 (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) employee 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) Employees 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 employees 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required training and drills for fire safety and evacuation. This had the potential to directly affect all 84 residents, staff, and visitors.	0 810		

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0 810	Continued From page 12 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and 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: On November 2, 2021, at approximately 11:30 a.m., the licensed assisted living director (LALD)-A provided records for review. Records were reviewed by survey staff on November 2, 2021, between 11:30 a.m. and 11:50 a.m. 1. Fire Drill Policy 8.07 dated January 16, 2017 contained procedures for evacuation drills but no evacuation drill logs were provided for 2021. 2. Fire Policy 8.05 and Emergency Preparedness Overview documentation was reviewed. a. Fire safety and evacuation training for residents was provided at admission. Facility failed to provide additional annual fire safety and evacuation training for residents. b. Fire safety and evacuation training for staff was provided upon hire and annually. Facility failed to provide the required staff training frequency of at least twice per year after hire. On November 2, 2021, at approximately 11:55 a.m., (LALD)-A confirmed during exit interview that the facility failed to provide the required training frequency on fire safety and evacuation for residents and staff. They also confirmed that no evacuation drills had been performed in 2021. No further information was provided.	0 810		

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0 810	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	0 950		

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0 950	Continued From page 14 Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for two of five residents (R1 and R2) 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: R1's service plan dated October 14, 2021, indicated the resident received services which included medication administration, blood glucose monitoring, laundry and housekeeping. R1's Resident Lease and Services Agreement dated October 12, 2021, included the Designated Representative form which was blank. On November 2, 2021, at 9:05 a.m., registered nurse (RN)-F confirmed R1 had not been provided the opportunity to identify a designated representative. R2's service plan dated October 22, 2021, indicated the resident received services which included medication administration, oxygen therapy, wound care, blood glucose monitoring, laundry and housekeeping. R2's Resident Lease and Services Agreement dated October 22, 2021, included the Designated	0 950		

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0 950	Continued From page 15 Representative form which was blank. On November 2, 2021, at approximately 10:05 a.m., licensed assisted living director (LALD)-A confirmed R2 had not been provided the opportunity to identify a designated representative. On November 3, 2021, at approximately 8:25 a.m., director of nursing (DON)-B confirmed the licensee did not have a policy regarding designated representatives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01530		

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01530	Continued From page 16 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia 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 one of three employees (unlicensed personnel (ULP)-I received the required amount of dementia care training. 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: ULP-I was hired on August 1, 2021, to provide direct care services under the licensee's Assisted Living license. On November 2, 2021, at approximately 7:51 a.m. ULP-I was observed assisting R5 with morning care and transferring R5. ULP-I training transcript indicated ULP-I completed 4.25 hours of dementia training. ULP-I's employee record lacked evidence ULP-I had completed the required eight hours of dementia training. On November 3, 2021, at approximately 9:30 a.m. administrative coordinator (AD)-K confirmed	01530		

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01530	Continued From page 17 ULP-I had not completed the required eight hours of dementia training as indicated above. The licensee's 3.02 Alzheimer's Disease and Related disorders-Training and Notification policy, last reviewed October 29, 2021, indicated the licensee will provide relevant training to care givers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered	01730		

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01730	Continued From page 18 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to one of one residents (R4) medication management plan related to the set up of medications by 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 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 completed medication setup for later administration for R4.	01730		

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R4's diagnoses included, but were not limited to, hypertension (high blood pressure), anxiety, right leg pain, and depression.

R4's service plan dated July 30, 2021, indicated the resident received services which included medication administration.

R4's prescriber orders dated October 13, 2021, included an order for acetaminophen 650 milligrams (mg) to be administered twice a day for pain.

On November 1, 2021, at approximately 1:55 p.m., the #5 medication cart was being reviewed with director of nursing (DON)-B and ULP-E. Observed in the top drawer of the locked medication cart was an unlabeled medication cup with two round white tablets. ULP-E verified the medication was two acetaminophen tablets for R4. ULP-E confirmed she had setup the medications around 1:05 p.m. and was saving the medication to administered to R4 later.

On November 1, 2021, at approximately 2:00 p.m., DON-B confirmed ULP should not be setting up medications for later administration.

On November 2, 2021, at approximately 6:35 a.m., licensed assisted living director (LALD)-A confirmed the licensee did not have a policy regarding medication setup.

According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making.

MN Statute 144G.08, Subd. 41. Medication

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01730	Continued From page 20 setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments; permit only authorized personnel access; and failed to ensure medications were stored according to manufactures recommendations. 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:	01880		

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01880	Continued From page 21 The findings include: On November 1, 2021, at approximately 2:10 p.m. medication refrigerator located in the nurse's station was unlocked. The nurse's station was open to the hallway. The following medications were in the medication refrigerator: Resident (R) 8's bottle of Latanoprost 0.005% eye drops (treatment for glaucoma), and 10 Bisacodyl 10 mg (milligram) rectal suppositories; R9's 3 Bisacodyl 10 mg rectal suppositories; and R10's bottle of Timolol 0.5% eye drops (treatment for glaucoma). On November 1, 2021, at approximately 2:15 p.m. director of nursing (DON)-B confirmed the medication refrigerator was not locked and R8 and R9's Bisacodyl rectal suppositories were stored in the medication refrigerator. DON-B stated the Bisacodyl suppositories are not to be stored in the refrigerator. The licensee's 5.11 Storage of Medication policy reviewed October 31, 2021, indicated medications must be stored in securely locked in substantially constructed compartments and permit only authorized personnel to have access. Medications shall be stored consistent with manufactures recommendations. FDA (Food and Drug Administration) storage requirements for Bisacodyl rectal suppositories dated November 23, 2020, indicated Bisacodyl rectal suppositories should be stored at room temperature between 58 degrees to 86 degrees Fahrenheit. No further information was provided.	01880		

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01880	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were not used beyond the expiration date. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a 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: On November 1, 2021, at approximately 1:38 p.m., the locked medication carts were reviewed with director of nursing (DON)-B. The following was observed and confirmed by DON-B. Medication cart #3 contained the following expired medications:	01890		

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01890	Continued From page 23 R11 had a bottle of Hydralazine (treat high blood pressure 25 mg (milligrams), labeled do not use past August 4, 2021; R12 had two bottles of Mapap (pain medication) 500 mg /15 ml (milliliters) with an expiration date of October 14, 2021; and R13 had a bottle of Miralax (treat constipation) with an expiration date of July 2021. Medication cart #4 contained the following expired medications: R14 had a bottle of Morphine (pain medication) with an expiration date of September 21, 2021, and a bottle of lorazepam with an expiration date of October 18, 2021; R15 had a bottle of Trazodone (treat depression) 50 mg with an expiration date of February 5, 2021; and R16 had a bottle of acetaminophen (pain medication) 500 mg with a expiration date of October 9, 2021. On November 1, 2021, at approximately 1:38 p.m. DON-B stated the registered nurse (RN) working the night shift is to audit the medication cart nightly. The licensee's NOC (night) Medication Cart Audit form indicated the medication cart audit will be completed nightly to check labels for discontinues, missing labels, expired medications, open and undated medication, missing labels and to re-order narcotics. The NOC Medication Cart Audit for indicated the medications were audited by the registered nurse (RN) on October 30, and 31, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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01890	Continued From page 24 days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the client's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01910		

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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:
R7's record lacked documentation of medication disposition upon discharge.
R7's medication administration summary for October 2021, indicated R7 received the following medications;
-Levothyroxine (treat thyroid disease) 75 mcg (micrograms) on tablet daily;
-omeprazole (anti acid) 20 mg (milligrams) every day before breakfast;
-Metolazone (treat edema) 2.5 mg daily
-Digoxin .125 mg daily
-Ferrous Sulfate 325 m;
-Isosorbide Mononitrate (treat chest pain) 30 mg
-Prednisone (treat inflammation) 5 mg daily and
-Torsemide (treat fluid retention) 20 mg.

R7's Discharge Summary dated October 29, 2021, indicated R7 received medication management services. Staff members were to administer medications according to prescriber's orders. Medications were destroyed in vinegar with a nurse and a witness.

R7's record lacked evidence of documentation of R7's disposition of medications to include: name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition.

On November 3, 2021, at approximately 9:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE BLUFFS	2528 TRINITY ROAD DULUTH, MN 55811

(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
01910	Continued From page 26 a.m. director of nursing (DON)-B confirmed R7's record lacked documentation of disposition of medications as indicated above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 84 current clients, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	11/03/2021

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(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
03090	Continued From page 27 The findings include: On November 1, 2021, at approximately 12:25 p.m.,Minnesota Department of Health surveyors entered the facility. There was no signage posted in the entry way of the facility regarding electronic monitoring devices. On November 1, 2021, at approximately 12:35 p.m., the licensed assisted living director (LALD)-A stated they had cameras throughout the facility in common areas. LALD-A confirmed the licensee did not have signage posted in the entry way regarding electronic monitoring. On November 1, 2021, at approximately 1:35 p.m., LALD-A provided the licensee's policy book. The licensee lacked a policy regarding postings related to electronic monitoring devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		