



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 13, 2025

Licensee

Keystone Bluffs Assisted Living

2528 Trinity Road

Duluth, MN 55811

RE: Project Number(s) SL29456016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 2024, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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>

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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,



Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE BLUFFS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 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
0 000	Initial Comments 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: SL294560160 On December 9, 2024, through December 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 81 residents; 79 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 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 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.		
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on November 3, 2021. 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	0 340			

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0 340	Continued From page 2 or has the potential to affect a large portion or all of the residents). The findings include: On December 9, 2024, at 10:23 a.m., licensed assisted living director (LALD)-A stated the licensee had a plan of correction (POC/correction action plan (CAP). On December 9, 2024, at 12:20 p.m., the surveyor was given a correction binder for review. On December 9, 2024, at 1:20 p.m., LALD-A stated some corrections were made, completed right after the last survey. LALD-A said the corrections made at the facility were not kept up to date. On December 11, 2024, at approximately 3:30 p.m., the survey concluded, and the following orders were reissued from the previous survey: 0470, 0480, 0650, 0680, 1530, 1880, 1890. In addition to the orders reissued, the following orders were issued: 0510, 0660, 1420, 1560, 1640, 1710, 1750, 1760, 1950, 1960, 2310, 2320, 2350, and 2430. On December 11, 2024, at 10:55 a.m., LALD-A said there had been 100% turn over for staff, and "they" [LALD-A and clinical nurse supervisor (CNS)-C] could only "speak" to the last six months. LALD-A and CNS-C said it looked like prior staff "started" on the CAP. CNS-C stated she knew there was work to do at the facility when she accepted the position. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 340			

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0 340	Continued From page 3	0 340			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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 observation, interview, and document review, the licensee failed to ensure an evaluation was conducted at least twice a year, of the appropriateness of staffing levels in the facility.	0 470			

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0 470	Continued From page 4 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: The licensee held an assisted living facility license. The facility was licensed for 100 residents and had a current census of 81 residents. On December 9, 2024, at 10:45 a.m., during the entrance conference with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C, CNS-C stated the facility's staffing plan had been reviewed but she could not remember the exact date. LALD-A stated the daily staff schedule was: -five unlicensed personnel (ULP) worked from 6:00 a.m. until 2:00 p.m. -four ULP worked from 2:00 p.m. until 10:00 p.m. -three ULP worked from 10:00 p.m. until 6:00 a.m. The licensee's Acuity Review (staffing plan) authenticated by CNS-C, and dated July 17, 2024, noted: residents -independent: 33 -assist of one: 35 -assist of two: 0 -Sara Steady (transfer assist machine): 9 -Sit to Stand (type of mechanical lift): 2 -Hoyer (sling type of mechanical lift): 2 -side rails (bed rails): 16	0 470			

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0 470	Continued From page 5 -Hospice: 3 -behaviors: 9 -turn and reposition: 1 -glucose monitoring: 15 -greater than 10 medications: 50 -ROM (range of motion)/walking: 3 -nebulizer s(mall machine that creates a mist out of liquid medication, allowing for quicker and easier absorption of medication into the lungs): 4 -CPAP (treat obstructive sleep apnea/device that delivers pressurized air to keep the airway open during sleep): 4 -oxygen: 7 -catheter (a tube inserted into the bladder, allowing urine to drain freely): 7 -ostomy: 2 -wound care: 23 -brace/TEDs (compression stocking): 30 -smoker: 3 -other: falls: 16 -toileting/incontinence program: 23. On December 9, 2024, at 1:51 p.m., the surveyor requested the prior staffing plan. On December 11, 2024, at 8:41 a.m., CNS-C stated RN-B was working on staffing plans now, in the corporate office. On December 11, 2024, 10:53 a.m., CNS-C said she could not find another completed staffing plan prior to the one she completed. CNS-C confirmed the licensee failed to evaluate staffing needs at least twice a year, for the appropriateness of staffing levels in the facility. On December 11, 2024, at 10:55 a.m., LALD-A said there had been 100% turn over for staff, and "they" (LALD-A and CNS-C) could only "speak" to the last six months.	0 470			

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0 470	Continued From page 6 The licensee's Staffing & Scheduling policy dated October 24, 2024, noted Twin Diamond Operator would assure qualified employees would be scheduled to meet operational requirements and the needs of the residents. The CNS would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24 hours a day, seven-days a week. The licensee's Person-Centered Care policy dated December 4, 2024, noted clinical nurse supervisors would evaluate staffing levels at least twice a year to ensure sufficient staffing to meet the scheduled and reasonably foreseeable unscheduled needs of each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
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	0 480			

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0 480	Continued From page 7 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; (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.	0 480			

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0 480	Continued From page 8 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 December 11, 2024, for the specific Minnesota Food Code violations. The 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			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and	0 510			

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0 510	Continued From page 9 control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 ensure infection control standards were followed by one of two unlicensed personnel (ULP)-F while providing direct care to residents. 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 December 10, 2024, at 9:28 a.m., the surveyor observed ULP-F wash hands and apply gloves. ULP-F lifted up R23's shirt and said, you have "Kleenex" in there, as ULP-F threw the tissues R23 tucked up under her breasts into a trash can. ULP-F opened a package of towelettes, applied soap and water. ULP-F cleaned under R23's right breast. ULP-F tossed the used towelette into the trash and prepared another towelette, applied soap and water. ULP-F cleaned under R23's left breast. ULP-F stated the soap did not require to be rinsed. ULP-F patted the areas dry. ULP-F removed gloves. The surveyor did not observe ULP-F perform hand	0 510			

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0 510	Continued From page 10 hygiene. On December 10, 2024, at 9:35 a.m., the surveyor observed ULP-F apply gloves. ULP-F applied Nystatin powder (yeast/ antifungal medication) under R23's right breast. ULP-F applied Nystatin powder under R23's left breast. ULP-F removed gloves. ULP-F applied clean gloves. The surveyor did not observe ULP-F perform hand hygiene before after medication administration. On December 10, 2024, at 9:38 a.m., ULP-F used a dry towel, while she stated "I" am going to wipe all this "extra stuff (Nystatin powder) off you" while ULP-F brushed off R23's pants. On December 10, 2024, at 9:40 a.m., ULP-F removed gloves and started to push R23's wheelchair into the living area. R23 asked ULP-F to apply her "stockings" (compression). ULP-F washed her hands in the bathroom sink, applied gloves and applied lotion to R23's left leg and applied a compression stocking. ULP-F applied lotion to R23's right leg and applied a compression stocking. ULP-F applied a sock to R23's left foot and a shoe to R23's right foot. ULP-F removed gloves. On December 10, 2024, at 9:49 a.m., the surveyor observed ULP-F apply new gloves, fold over the top of R23's compression stocking, return the lotion. ULP-F removed gloves and washed hands. On December 10, 2024, at 9:55 a.m., ULP-F stated she washes her hands "really good before" she applied gloves. ULP-F added she normally does not wash her hands in-between cares, as she changes gloves very quickly. ULP-F stated	0 510			

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0 510	Continued From page 11 she changed gloves when she changed areas (went from one area to another.) The surveyor did not observe ULP-F perform hand hygiene in between glove changes, to include medication administration. On December 10, 2024, at 11:19 a.m., clinical nurse supervisor (CNS)-C stated hand hygiene should be done anytime gloves were removed. The licensee's Hand Washing policy dated May 14, 2024, noted when conducting a procedure required the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled 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;	0 650			

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0 650	Continued From page 12 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained required content for one of three employees (clinical nurse supervisor (CNS-C)). 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: CNS-C was hired on September 29, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On December 9, 2024, during the entrance conference at 10:26 a.m., CNS-C identified herself as the CNS for the facility. CNS-C's employee record did not include all required documentation to include:	0 650			

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0 650	Continued From page 13 -annual performance review. On December 10, 2024, at 2:21 p.m., housing coordinator/unlicensed personnel (HC/ULP)-I stated an annual performance review was not completed for CNS-C as required. HC/ULP-I said CNS-C had worked for the licensee but in a different position and CNS-C's review got missed. The licensee's Employee Records policy dated October 24, 2024, noted each employee record would include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	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.	0 660			

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0 660	Continued From page 14 This MN Requirement is not met as evidenced by: Based on 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). The licensee failed to complete a TB risk assessment annually. This had the potential to affect all residents. 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 December 9, 2024, at 10:50 a.m., the surveyor requested the facility TB risk assessment. Clinical nurse supervisor (CNS)-C stated the form was completed on December 9, 2024, low risk. On December 9, 2024, at 12:35 p.m., licensed assisted living director (LALD)-A stated the TB risk assessment on file was from 2020. LALD-A said CNS-C updated the TB form this day and asked the surveyor if she wanted that TB form for review. Directly after the above statement, the surveyor reviewed the facility previous TB risk assessment: -date worksheet completed: June 28, 2021.	0 660			

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0 660	Continued From page 15 The licensee's Tuberculosis Plan policy dated December 31, 2023, noted [licensee's] facilities shall have a current infection control plan that included a community TB risk assessment: -the facility shall complete a written community TB risk assessment and update the assessment data on an (sic) periodically as state information was available. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated February 3, 2022, and based on CDC guidelines, indicated a TB risk assessment should be completed on an annual basis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
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; (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 residents.	0 680			

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0 680	Continued From page 16 (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 observation, interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents, staff and visitors. 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: On December 9, 2024, at approximately 10:55 a.m., during the entrance conference licensed assisted living director (LALD)-A stated the facility's EPP was in her office. On December 9, 2024, at 11:01 a.m., during a tour of the facility with LALD-A and clinical nurse supervisor (CNS)-C, the surveyor did not observe	0 680			

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0 680	Continued From page 17 the facility's EPP or signage regarding the EPP's location. LALD-A stated the facility's EPP was kept in the office. LALD-A said the office was locked when she was not in the building. LALD-A confirmed the facility's EPP was not posted prominently. On December 9, 2024, at 12:14 p.m., LALD-A stated the facility's EPP was her weak spot adding she started in June (employment). The facility's EPP risk assessment template was dated 2024, however no completion date was noted. On December 9, 2024, at 1:20 p.m., LALD-A and the surveyor reviewed the facility's EPP. Registered nurse (RN)-B also was involved with the review of the EPP. LALD-A stated arrangements with other health care facilities were done right after the last survey but not kept up to date, dated 2021. LALD-A repeated she had been at the facility since June (2024). LALD-A stated she was not aware the missing resident plan required quarterly review. LALD-A said what she saw in the EPP was a "bunch of policies." LALD-A added, the binder was "useless." LALD-A stated there may be more at the corporate office, but the EPP needed to be here (on site). On December 9, 2024, at 1:34 p.m., RN-B stated there was not a chain of commands "on paper." RN-B also said, the facility had arrangements with other facilities, however they were not in writing. The licensee's EPP lacked the following content and/or policies and procedures to address: - a comprehensive program to include man-made disasters, infectious diseases and	0 680			

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0 680	Continued From page 18 pandemics - a description of the population served by the licensee - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations - the facilities role in providing care and treatment at alternative sites - the provision of subsistence needs for staff and residents - a tracking system used to document locations of residents and staff - an evacuation plan - the medical record documentation system the facility has developed to preserve resident information security and availability of records. In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification 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 December 9, 2024, at 1:50 p.m., LALD-A and the surveyor concluded the review of the facility's EPP. LALD-A and RN-B confirmed the licensee had only the shelter in place area addressed, last completed August 2023.	0 680			

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0 680	Continued From page 19 The licensee's Disaster and Emergency Preparedness Plan policy dated January 1, 2024, noted it was the policy of the licensee to be compliant with emergency preparedness and at least annually review and update the emergency preparedness plan, any related policies, and facility and patient population assessment as necessary. The licensee would follow the guidelines and recommendations- during emergency situations- of state agencies under with they were licensed. To the extent possible, they would follow the statues under 144G during emergency situations. The licensee's Missing Client (resident) policy reviewed July 14, 2021, noted [licensee] would review the missing person policy annually and any individual resident plans that pertain to elopement at least quarterly, and all changes would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780			

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0 780	Continued From page 20 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions have the ability to affect all staff and residents. 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 potential to affect a large portion or all of the residents). Findings include: On facility tour with the registered nurse (RN)-B and director of maintenance (DM)-O on December 11, 2024, between 9:00 a.m. and 12:45 p.m. the following deficient conditions were observed:	0 780			

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0 780	Continued From page 21 FIRE RATING/DOORS: The surveyor observed that there many labeled fire doors throughout the facility being held open by various devices. The storage room door by resident room 506 did not fully close and latch. The surveyor explained to the RN-B and DM-O that all resident room doors as well as all storage/mechanical room doors to the corridors shall close and latch under their own power and remain closed all the time unless on a hold open device connected to the fire alarm system. CARBON MONOXIDE: The surveyor observed that there were areas that were not protected by carbon monoxide detectors. The surveyor explained to the RN-B and DM-O that carbon monoxide detectors with sounding bases shall be installed in these areas. The deficient conditions were visually verified by the RN-B and DM-O accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to	01420			

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01420	Continued From page 22 demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided written instructions in the resident's record for the delegated task provided by the unlicensed personnel (ULP) for one of one resident (R10) whose delegated task included catheter care. 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: R10's diagnoses included obstructive and reflux uropathy (urine flow blocked /partially or completely), retention of urine (bladder not emptying), and chronic kidney disease (loss of kidney function). R10's Service Plan dated October 3, 2024,	01420			

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01420	Continued From page 23 indicated R10 received the service: empty urinary catheter (a tube inserted into the bladder, allowing urine to drain freely) drainage bag four times daily. On December 10, 2024, at approximately 6:45 a.m., the surveyor observed R10 sitting in a recliner and a catheter bag was seen in a basin near R10. ULP-J used a Sara Steady (transfer assist machine) to transfer R10 from recliner into bathroom. ULP-J had a catheter leg bag in her hand. R10's Rtasks (computer system used) catheter care 7:00 a.m., instruction sheet noted: -change from night drainage bag to leg bag before breakfast and leg bag to night drainage bag at bedtime. Skilled Home Care Agency responsible for changing/irrigating the catheter. On December 11, 2024, at 12:13 p.m., R10's record was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated R10's record did not include specific instructions for R10's catheter, such as issues to be reported: decreased urine output, change in color of urine, or complaints of pain or discomfort. CNS-C added every resident needed a review of their records for missing information. The licensee's Delegation of Assisted Living Services dated August 15, 2024, noted the RN would specify, in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420			

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01530 SS=F	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 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 two of two employees, (unlicensed personnel (ULP)-D, ULP-F) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530			

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01530	Continued From page 25 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: ULP-D ULP-D was hired on July 18, 2024, to provide direct care and services to the licensee's residents. On December 10, 2024, at 9:02 a.m., ULP-D handed R18's two prepared medication cups to ULP-E. ULP-D's employee record included a transcript that noted: -dementia-activities- a balanced approach, dated July 7, 2024, 0.75 hours. -dementia- activities- bathing, completed July 7, 2024, 0.75 hours. -dementia- activities- chores, working, and volunteering, completed July 8, 2024, 0.75 hours. -dementia- activities- dressing and grooming, completed July 8, 2024, 0.75 hours. -dementia- activities- leisure and life enriching activities, completed July 8, 2024, 0.75 hours. -dementia- activities- toileting, completed July 8, 2024, 0.50 hours. -dementia- person-centered care, completed July 8, 2024, 0.75 hours. ULP-D's employee record included five hours of dementia training. ULP-D's employee record lacked three hours of the required eight hours of dementia training.	01530			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE BLUFFS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2528 TRINITY ROAD DULUTH, MN 55811		
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01530	Continued From page 26 ULP-F ULP-F was hired on February 21, 2024, to provide direct care and services to the licensee's residents. On December 10, 2024, at 9:35 a.m., the surveyor observed ULP-F apply Nystatin powder under R23's left breast. ULP-F's employee record included a transcript that noted: -dementia-activities- a balanced approach, dated February 26, 2024, 0.75 hours. -dementia- activities-bathing, completed February 27, 2024, 0.75 hours. -dementia- activities- chores, working, and volunteering, completed February 27, 2024, 0.75 hours. -dementia- activities- dressing and grooming, completed February 27, 2024, 0.75 hours. -dementia- activities- leisure and life enriching activities, completed February 27, 2024, 0.75 hours. -dementia- activities- toileting, completed February 27, 2024, 0.50 hours. -dementia- person-centered care, completed February 27, 2024, 0.75 hours. ULP-F's employee record included five hours of dementia training. ULP-F's employee record lacked three hours of the required eight hours of dementia training. On December 10, 2024, at 2:28 p.m., clinical nurse supervisor (CNS)-C stated ULP-D worked full time and should have worked 160 hours by this time. The surveyor reviewed ULP-D's transcript with CNS-C. CNS-C stated ULP-D did not have the topics required or the hours of dementia training required.	01530			

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01530	Continued From page 27 On December 10, 2024, at 3:07 p.m., staff coordinator/unlicensed personnel (SC/ULP)-I stated the corporate office was looking into what or how dementia hours required and topics "dropped off." On December 10, 2024, at 3:37 p.m., the surveyor received an email from SC/ULP-I that noted the two staff reviewed (ULP-D, ULP-F) had worked over 160 hours. On December 11, 2024, at 8:52 a.m., licensed assisted living director (LALD)-A stated director of operations (DO)-M looked into the dementia training issues, and the staff hired in 2024 did not receive the required dementia training. The licensee's Dementia Training policy dated October 23, 2024, noted direct care employees would compete eight hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01560 SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living;	01560			

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01560	Continued From page 28 (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure dementia training included all the required content for two of two employees, unlicensed personnel (ULP)-D, 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) 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: ULP-D ULP-D was hired on July 18, 2024, to provide direct care and services to the licensee's residents. On December 10, 2024, at 9:02 a.m., ULP-D handed R18's two prepared medication cups to ULP-E. ULP-D's employee record included a transcript that noted:	01560			

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01560	Continued From page 29 -dementia-activities- a balanced approach, dated July 7, 2024 -dementia- activities-bathing, completed July 7, 2024 -dementia- activities- chores, working, and volunteering, completed July 8, 2024 -dementia- activities- dressing and grooming, completed July 8, 2024 -dementia- activities- leisure and life enriching activities, completed July 8, 2024 -dementia- activities- toileting, completed July 8, 2024 -dementia- person-centered care, completed July 8, 2024. ULP-D's employee record lacked evidence ULP-D received the following dementia training: -the explanation of Alzheimer's disease and other dementia -communication skills, On December 10, 2024, at 2:28 p.m., the surveyor reviewed ULP-D's transcript with clinical nurse supervisor (CNS)-CNS-C. CNS-C stated ULP-D did not have the topics required of dementia training required. ULP-F ULP-F was hired on February 21, 2024, to provide direct care and services to the licensee's residents. On December 10, 2024, at 9:35 a.m., the surveyor observed ULP-F apply Nystatin powder under R23's left breast. ULP-F's employee record included a transcript that noted: -dementia-activities- a balanced approach, dated February 26, 2024	01560			

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01560	Continued From page 30 -dementia- activities-bathing, completed February 27, 2024 -dementia- activities- chores, working, and volunteering, completed February 27, 2024 -dementia- activities- dressing and grooming, completed February 27, 2024 -dementia- activities- leisure and life enriching activities, completed February 27, 2024 -dementia- activities- toileting, completed February 27, 2024 -dementia- person-centered care, completed February 27, 2024 ULP-F's employee record lacked evidence ULP-D received the following dementia training: -the explanation of Alzheimer's disease and other dementia -communication skills, On December 11, 2024, at 8:52 a.m., licensed assisted living director (LALD)-A stated director of operations (DO)-M looked into the dementia training issues, and the staff hired in 2024 did not receive the required dementia content training. The licensee's Dementia Training policy dated October 23, 2024, noted direct care employees would compete eight hours of initial training within 160 hours of the employment start date. Required dementia training topics include: -an explanation of Alzheimer's disease and other dementia's -assistance with activities of daily living -problem solving with challenging behaviors -communication skills -person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01560			

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01560	Continued From page 31 (21) days	01560			
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 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 service plans were revised/implemented as required for three of four residents (R10, R14, R20). In addition, the licensee failed to ensure service plans were authenticated to confirm agreement of the services to be provided for two of four residents (R17, R18).	01640			

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01640	Continued From page 32 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 potential to affect a large portion or all of the residents). The findings include: R10 R10's diagnoses included diabetes, retention of urine, chronic kidney disease (kidneys are damaged and can't filter blood effectively) and depression. R10's service plan dated October 3, 2024, indicated R10 received the following service: -weight: two times a week. R10's prescriber's order dated May 31, 2024, included: -weight: two times a week. R10's service recap summary dated December 1, 2024, through December 10, 2024, lacked to include: -weights two days per week. On December 10, 2024, at approximately 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-J use a Sara Steady (transfer assist machine) to transfer R10 from recliner into bathroom. R10's service plan had noted weights were done twice a week, however R10's weights were not currently monitored.	01640			

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01640	Continued From page 33 On December 11, 2024, at 12:10 p.m., registered nurse (RN)-N stated she had not "seen" weights two times a week on R10's prescriber order and added R10 did not currently receive that service (monitor of weight twice a week). RN-N said she was not sure why R10's service plan noted weight, two times a week. RN-N stated it was possible at one time R10's weights twice a week had been ordered and the service plan had not been corrected when the service was not longer required. RN-N confirmed R10's service plan was not updated as required nor where R10's weight monitoring implemented. R14 R14's diagnoses included diabetes. R14's service plan dated July 30, 2021, indicated R14 received the following services: diabetic foot checks, fall coordination, medication administration, mobility assist and housekeeping services. R14's service recap dated December 1, 2024, through December 10, 2024, included: -if blood sugar is below 70 and client is alert and able to swallow, give a glass of juice. Recheck blood sugar in five minutes before escorting to meal. Then escort to the dining room and ask kitchen staff to give them their meal. If at HS (hour of sleep), give a full sandwich and call nurse if BG does not go up over 100. If blood sugar is greater than 400, then give two glasses of water, limit sweets and notify nurse. R14's prescriber order dated December 9, 2024, included: -d/c (discontinue) scheduled BG checks -BG check as needed for symptoms of	01640			

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01640	Continued From page 34 hypoglycemia (low blood sugar) On December 10, 2024, at 6:55 a.m., RN-G placed a BG testing strip into a BG meter, cleansed R14's middle finger on left hand, used a lancet to collect a BG sample to receive a BG level of 179. R14 told RN-G "I thought we were not doing that [BG] monitoring anymore." R14's service plan dated July 30, 2021, did not include BG monitoring. R20 R20's diagnoses included weakness, insomnia, dizziness, irritable bowel syndrome, and major depressive disorder. R20's service plan dated February 1, 2022, indicated R20 received the following services: COVID monitoring (oxygen and temperature/daily) fall coordination, medication administration, mobility assist and housekeeping services. On December 10, 2024, at 7:47 a.m., the surveyor observed ULP-D prepare and administer R20's morning medication. R20's services did not include COVID monitoring. On December 11, 2024, at 10:58 a.m., clinical nurse supervisor (CNS)-C stated she was not aware service plan needed to be revised with changes to services. CNS-C said service plans were reviewed with 90-day assessments. CNS-C added she had seen some service plan addendum forms and had wondered what they were for. SERVICE PLAN AUTHENTICATION	01640			

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01640	Continued From page 35 R17 R17's diagnoses included atrial fibrillation (A-fib /an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), chronic systolic congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), rheumatoid arthritis, major depressive disorder, hypertension (high blood pressures/ HTN) and chronic kidney disease. R17's record did not include a service plan. R17's medication assessment dated November 25, 2024, noted: -medication kept in locked medication carts and will be put in weekly pill box for resident per her request. The pill box would be kept in apartment. MD (medical doctor) order being faxed today updating her mediation management plan. On December 10, 2024, at 7:24 a.m., the surveyor observed ULP-D removed R17's medication one at a time and put the medications into a medication cup. On December 10, 2024, at 7:30 a.m., the surveyor observed ULP-D take the medication cup to R17's room and begin to administer. R17's morning medication. R18 R18's diagnosis included chronic respiratory failure/chronic obstructive pulmonary disease (COPD, chronic inflammatory lung disease that causes obstructed airflow from the lungs), bone pain, hypokalemia (low potassium), hypothyroid, hypercholesterolemia (high cholesterol), major depressive disorder, and anxiety.	01640			

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01640	Continued From page 36 R18's record did not include a service plan. R18's RTasks (computer system used) included: -dated November 25, 2024, place lymphedema pump on right leg two days per week for 30 minutes per time. R18's prescriber order dated February 16, 2024, included: -medication administration 14 times per day and daily -edema wear: Jobst compression stocking put on in a.m. (morning) and off at p.m. (evening). On December 10, 2024, at 10:45 a.m., the surveyor observed RN-G administer R18's medication. R18 wore a NC. The surveyor observed RN-G attempt to start R18's lymphedema leg pump. On December 11, 2024, at 8:21 a.m., CNS-C stated R17's and R18's service plans were not signed. On December 11, 2024, at 11:19 a.m., CNS-C stated getting service plans signed was a "big problem." CNS-C said some of the resident's refuse to sign the service plans. On December 23, 2024, at 11:43 a.m., via email communication CNS-C noted, she was not able to locate a signed or unsigned copy of either one (R17, R18) service plans. CNS-C added she knew RN-L handed them (service plans) off to the resident's (R17, R18) but RN-L did not document R17, or R18 refused to sign and there was no copy of R17 or R18's previous service plans. CNS-C noted Rtasks (computer system used) did not allow for a previous service plan to be printed.	01640			

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01640	Continued From page 37 The licensee's Service Plan policy dated effective January 1, 2025, (sic) noted the service plan and any revisions shall include a signature or other authentication by Twin Diamond Operator and by the resident, or resident's representative, documenting agreement on the services to be provided. Services plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment for one of three residents (R17) who received medication management 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 an isolated scope (when one or a limited number of	01710			

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01710	Continued From page 38 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R17's diagnoses included atrial fibrillation (A-fib /an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), chronic systolic congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), rheumatoid arthritis, major depressive disorder, hypertension (high blood pressures/ HTN) and chronic kidney disease (kidneys are damaged and can't filter blood effectively). R17's record did not include a service plan. R17's medication assessment dated November 25, 2024, noted: -resident wanted RNCM (registered nurse case manager) to set up medication weekly. It was discovered in this planning process that (facility name) license does not allow for this. Resident agreeable to keeping them on medication cart and given by staff -medication kept in locked medication carts and will be put in weekly pill box for resident per her request. The pill box would be kept in apartment. MD (medical doctor) order being faxed today updating her mediation management plan. -difficulty swallowing whole pills; uses knife to spilt pills herself as the cannot use the pill cutter. This will be a non-issue going forward as pharmacy will be preparing spilt pills in blister packs, and RNCM assisting with medication set up weekly will cut pills for resident with pill cutter. R17's December 1, 2024, through December 10,	01710			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29456	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER KEYSTONE BLUFFS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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
01710	Continued From page 39 2024, medication administration record (MAR) noted: -famotidine (stomach acid) 20 milligrams (mg) two times a day -gabapentin (nerve pain) 300 mg give two tablets by mouth at bedtime -magnesium- calcium carbonate (supplement) 71.5/119 mg give two tablets twice daily -sulfasalazine (bowel disease) 500 mg two tables every morning -Tylenol (mild pain) 1000 mg three times a day -multiple vitamin (self-administer) give one tablet by mouth daily -amiodarone (a-fib)200 mg one tablet two times a day for five days, then one tablet on time a day for 90 days -Eliquis (a-fib)5 mg one tablet two times a day -Fosamax (bone loss) 70 mg one tablet on time a week, with plan water -furosemide (diuretic) 20 mg, give half tablet daily -hydroxychloroquine (rheumatoid arthritis) 200 mg with food daily -losartan (HTN) 25 mg give half tablet daily -metoprolol tartrate (HTN) 50 mg twice daily -prednisone(inflammation) 5 mg daily -aspirin EC (enteric coated/heart health) 81 mg daily, do not spilt or crush -calcium carbonate- vitamin D3 (supplement) 1200 daily -duloxetine (depression) 60 mg one tablet daily -ferrous sulfate (every two days) 325 mg given one tablet every other day, take with orange juice or citrus -levothyroxine 150 micrograms (mcg) one time daily. R17's prescriber order dated November 9, 2024, included the above orders. On December 10, 2024, at 7:24 a.m., the	01710			

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01710	Continued From page 40 surveyor observed ULP-D removed R17's medication one at a time and put the medications into a medication cup. On December 10, 2024, at 7:30 a.m., the surveyor observed ULP-D take the medication cup to R17's room. R17's husband had prepared a glass of juice and water for R17. R17 dumped the pills out onto the table. R17 went to the refrigerator and removed a jar of applesauce. R17 took the medication pills one at a time. R17 asked her husband to cut some of the medication in half. R17 stated, "some of the girls do it for us [cut the medication in half]." R17's record lacked an updated medication assessment, to include ULP would be preparing and administering medications. On December 10, 2024, at 4:01 p.m., the surveyor reviewed R17's medication assessment with RN-L. RN-L stated R17's medication assessment was an "error" on her part and needed to be correctly. RN-L stated that was how R17 and her husband wanted R17's medication set up she (RN-L) learned later that that license did not provide that type of service. The licensee's Medication & Treatment-Administration & Delegation policy dated August 15, 2024, noted a registered nurse must conduct a face-to-face resident assessment to determine what medication management or treatment/therapy services would be provided and how those service would be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710			

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01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, unlicensed personnel (ULP-F) demonstrated competency for administering medication. In addition, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for three of four residents (R16, R10, R2). 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:	01750			

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01750	Continued From page 42 MEDICATION COMPETENCY ULP-F began employment on February 21, 2024, to provide assisted living services to the licensee's residents. On December 10, 2024, at 9:35 a.m., the surveyor observed ULP-F apply gloves. ULP-F applied Nystatin powder (yeast/ antifungal medication) under R23's right breast. ULP-F applied Nystatin powder under R23's left breast. ULP-F's employee record included a transcript from Educare (on-line education system) which noted: -medication administration overview, completed August 22, 2024 -medication administration, routes, completed August 31, 2024. ULP-F's employee record included skills competency checklist dated May 21, 2024, which noted: -medications: topical medication, N/A (not applicable). ULP-F's record lacked evidence ULP-F had been deemed competent to administer topical medication. On December 10, 2024, at 1:47 p.m., clinical nurse supervisor (CNS)-C stated not all "non-medication passers" (some ULPs) were trained on topical medication administration. On December 10, 2024, at 2:35 p.m., CNS-C stated ULP-F was not trained or deemed competent on medication administration to include topical medication.	01750			

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01750	Continued From page 43 On December 10, 2024, at 11:21 a.m., CNS-C stated the licensee had been working on ensuring ULPs were trained to administer medication in topical/ powder form. CNS-C said the issue had not been corrected "across the board" yet. SPECIFIC INSTRUCTIONS R16 R16's diagnosis included diabetes. R16's service plan dated June 5, 2023, indicated R16 received medication administration. R16's medication administration record (MAR) dated December 1, 2024, through December 10, 2024, included: -Lantus (long acting) insulin 100 milliliters (ml)/unit, administer 22 units under the skin every morning. R16's prescriber order dated March 29, 2024, included the above medication. On December 10, 2024, at 7:11: a.m. the surveyor observed RN-G administer 22 units of Lantus into R16's left abdomen. Directly after the above observation RN-G stated he gave R16's insulin daily during the week. RN-G stated R16's record lacked documentation of insulin injection site. On December 10, 2024, at 7:21 a.m., CNS-C stated there was one resident that required a note regarding insulin administration. CNS-C added the note did not indicate what should be documented, just that the service required a "note." On December 11, 2024, at 12:20 p.m., R16's	01750			

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01750	Continued From page 44 record was reviewed with RN-N. RN-N stated R16's record did not include specific instructions for R16's Lantus administration to include injection site. R10 R10's diagnosis included diabetes. R10's service plan dated October 3, 2024, included medication administration. R10's MAR dated December 1, 2024, through December 10, 2024, included: -Humalog Kwikpen (short acting) insulin, inject 16 units under the skin three times a day with meals. Hold for blood sugar less than 120. R10's prescriber's order dated May 31, 2024, included the above medication. R10's record lacked documentation of insulin injection site. On December 10, 2024, at 4:31 p.m., the surveyor reviewed R10's record with RN-L. RN-L stated R10's MAR did not have specific directions for insulin administration. RN-L added, she knew as a nurse to rotate sites. RN-L confirmed there was no record for injections sites used and that RNs did not always administer R10's insulin. R2 R2's diagnosis included asthma/COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). R2's service plan dated July 30, 2021, indicated R2 received medication administration. R2's medication administration record (MAR)	01750			

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01750	Continued From page 45 dated December 1, 2024, through December 10, 2024, included: -Metamucil (fiber/bowel health), one tablespoon orally daily. R2's prescriber order dated July 25, 2024, included included the above medication. On December 10, 2024, at 9:08 a.m., the surveyor observed ULP-D prepare R2's morning medication which Metamucil . ULP-D handled R2 a glass of prepared Metamucil and R2 drank most of the Metamucil. ULP-D stated added she added a little extra water in the Metamucil. On December 10, 2024, at 9:08 a.m., ULP-D stated she gave R2 Metamucil to drink. ULP-D stated that was how R2 rinsed his mouth after inhaler and she added extra water to R2's Metamucil. R2's record was reviewed with ULP-D. ULP-D stated R2's MAR did not include how much water should be or what should be used to mix with R2's Metamucil. On December 10, 2024, at 11:15 a.m., CNS-C stated resident MARs should include specific instructions for ULPs to follow. The manufacturer's instructions for Lantus dated March 2020, noted rotate your injection sites with each does to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection. The manufacturer's instructions for Humalog dated April 2020, noted change inject site within the area you choose for each dose to reduce your skin of getting lipodystrophy and localized	01750			

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01750	Continued From page 46 cutaneous amyloidosis at the injection sites. The manufacturer's instructions for Metamucil dated 2022, noted put powder in empty glass, mix briskly with eight ounces or more of cold liquid, and drink promptly. Take this product at least two hours before or after medicines. The licensee's Medication & Treatment-Administration & Delegation policy dated August 15, 2024, noted when administration of medications or treatment/therapy was delegated or assigned to ULP the licensee would ensure that the registered nurse had: -instructed the unlicensed personnel in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the procedures. -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	01760			

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01760	Continued From page 47 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-D followed registered nurse (RN) written instructions for two of two residents (R2, R17). Additionally, the licensee failed to ensure medications were administered as ordered for three of three residents (R17, R20, R18). Further, the licensee failed to ensure manufacturer's instruction were followed for one of three residents (R17) who received medication management services. In addition, the licensee failed to ensure the steps of the medication administration process was followed by one of two employees, (ULP)-D, for three of four residents (R2, R20, R17). 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: FOLLOWING WRITTEN INSTRUCTION R2	01760			

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01760	Continued From page 48 R2's diagnosis included asthma/COPD (chronic inflammatory lung disease that caused obstructed airflow from the lungs). R2's service plan dated July 30, 2021, indicated R2 received medication administration. R2's medication administration record (MAR) dated December 1, 2024, through December 10, 2024, included: -Advair (COPD) 250/50 micrograms (mcg) inhale one puff twice daily. Rinse mouth after use. -Metamucil (fiber/bowel health) one tablespoon orally daily. R2's prescriber order dated July 25, 2024, included the above medications. On December 10, 2024, at 9:08 a.m., the surveyor observed ULP-D prepare R2's morning medication which included an Advair inhaler and Metamucil. ULP-D told the surveyor prior to entering R2's room that R2 did not take the inhaler correctly. ULP-D prepared and handed R2 the Advair inhaler, and R2 took a deep breath in. ULP-D handed R2 a glass of prepared Metamucil and R2 drank most of the Metamucil. ULP-D told the surveyor that by drinking the Metamucil which had water in it, R2's mouth was rinsed. ULP-D added she added a little extra water in the Metamucil. On December 11, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-C stated ULPs should follow written directions on the MAR. CNS-C added drinking a medication was not "rinsing the mouth." R17 R17's diagnoses included atrial fibrillation (A-fib	01760			

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01760	Continued From page 49 /an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), chronic systolic congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), rheumatoid arthritis, major depressive disorder, hypertension (high blood pressures/ HTN) and chronic kidney disease (kidneys are damaged and can't filter blood effectively). R17's record did not include a service plan. R17's December 1, 2024, through December 10, 2024, MAR noted: -Fosamax ((bone loss) 70 milligrams (mg), give one tablet by mouth one time a week. Take with plain water in the morning, 8:00 a.m. -famotidine (stomach acid) 20 mg two times a day, 8:00 a.m. -gabapentin (nerve pain) 300 mg give one tablet by mouth in morning, 8:00 a.m. -magnesium- calcium carbonate (supplement) 71.5/119 mg give two tablets twice daily, 8:00 a.m., -sulfasalazine (bowel disease) 500 mg two tables every morning, 8:00 a.m. -Tylenol (mild pain) 1000 mg three times a day, 8:00 a.m. -multiple vitamin (self-administer) give one tablet by mouth daily, 8:00 a.m. -amiodarone (a-fib) 200 mg one tablet two times a day for five days, then one tablet on time a day for 90 days, 8:00 a.m. -Eliquis (a-fib) 5 mg one tablet two times a day, 8:00 a.m. -furosemide (diuretic) 20 mg, give half tablet daily, 8:00 a.m. -hydroxychloroquine (rheumatoid arthritis) 200 mg with food daily, 8:00 a.m. -losartan (HTN) 25 mg give half tablet daily, 8:00	01760			

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01760	Continued From page 50 a.m. -metoprolol tartrate (HTN) 50 mg twice daily, 8:00 a.m. a.m. -prednisone(inflammation) 5 mg daily, 8:00 a.m. -aspirin EC (enteric coated/heart health) 81 mg daily, do not spilt or crush, 8:00 a.m. -calcium carbonate- vitamin D3 (supplement) 1200 daily, 8:00 a.m. -duloxetine (depression) 60 mg one tablet daily, 8:00 a.m. -ferrous sulfate (every two days) 325 mg given one tablet every other day, take with orange juice or citrus, 8:00 a.m. -levothyroxine 150 mcg one time daily, 7:00 a.m. R17's prescriber order dated December 9, 2024, included the above medication. On December 10, 2024, at 7:24 a.m., the surveyor observed ULP-D review R17's MAR and remove R17's medication, one at a time, and put all the medications listed on R17's December MAR into a medication cup. On December 10, 2024, at 7:30 a.m., the surveyor observed ULP-D take the medication cup to R17's room. R17's husband had prepared a glass of cranberry juice and water for R17. R17 dumped the pills out onto the table. R17 went to the refrigerator and removed a jar of applesauce. R17 took the medication pills one at a time, with applesauce. On December 10, 2024, at 7:40 a.m., R17 started to cough, and stated she had not had that happen before. R17 went to the sink and threw up. R17's husband stated "this" [throwing up] was normal. R17 stated she would try a piece of "this candy [chocolate] to see if "I can get it down [medication]."	01760			

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01760	Continued From page 51 On December 10, 2024, at 8:47 a.m., ULP-D stated she was "pretty positive" R17 took "that one" (Fosamax) with just plain water. On December 10, 2024, at 4:14 p.m., R17's record was reviewed with RN-L. RN-L stated ULP-D should have followed directions on the MAR for R17's medication administration. ADMINISTERED AS ORDERED R17's -ferrous sulfate was not administered with orange juice or citrus, and Fosamax was not administered with plain water. On December 10, 2024, at 11:27 a.m., CNS-C stated ULPs had a one-hour window for medication administration, so 7:00 a.m., and 8:00 a.m., medication could be given at the same time. On December 10, 2024, at 8:47 a.m., ULP-D confirmed R17 had eaten applesauce and chocolate during medication administration and that orange or citrus was not given with R17's ferrous sulfate. On December 12, 2024, at 4:14 p.m., the surveyor reviewed R17's record and the surveyor's medication observation of R17 with RN-L. RN-L stated R17's medications were not administered as ordered. RN-L added that was the first time she had heard that R17 had "thrown up (had difficulty swallowing)" and RN-L stated she should have been notified of that. RN-L stated she could not verify R17 received morning medications as ordered. R20 R20's diagnoses included weakness, insomnia,	01760			

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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
01760	Continued From page 52 dizziness, irritable bowel syndrome, and major depressive disorder. R20's service plan dated February 1, 2022, did not include medication administration. R20's assessment dated September 12, 2024, included: -all medications set up and administered by (name of licensee) staff -all medication kept in locked medication cart. R20's MAR dated December 1, 2024, through December 10, 2024, included: -psyllium husk (24 grams, stir one rounded tablespoon in eight ounces water daily; psyllium husk was circled, (not administered) ten of ten opportunities. -vitamin D3 give one capsule by mouth; vitamin D3 was circled, nine of ten opportunities. R20's prescriber order dated November 11, 2024, included the above medication. On December 10, 2024, at 7:47 a.m., ULP-D stated R20 declined psyllium husk every day. ULP-D said, R20 "hated it" and questioned why it continued to be ordered. ULP-D said she was not sure why R20's case manager had not removed the medication from R20's MAR. On December 11, 2024, at 11:13 a.m., CNS-C stated RNs were supposed to review MARs daily. On December 11, 2024, at 11:17 a.m., CNS-C stated RNs were not very good at reviewing MAR and added the process should be completed daily and medications should then be reordered. CNS-C stated it should not be "weeks" that medications were not administered as ordered.	01760			

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01760	Continued From page 53 R18 R18's diagnosis included chronic respiratory failure/chronic obstructive pulmonary disease (COPD, chronic inflammatory lung disease that causes obstructed airflow from the lungs), bone pain, hypokalemia (low potassium), hypothyroid, hypercholesterolemia (high cholesterol), major depressive disorder, and anxiety. R18's record did not include a service plan. R18's MAR dated December 1, 2024, through December 10, 2024, included: -Stiolto Respimat inhalant (COPD) 2.5-2.5 mcg take two puffs into the lungs daily -potassium chloride, take two tablets by mouth one time a day with breakfast and one tablet one time a day with supper -phosphorus (K Phos Neutral)/ supplement) 250 mg, give two tablets by mouth one time a day with meals. May add a couple drops of water to turn into paste and administer with pudding. Do not crush. R18's prescriber order dated October 12, 2024, included: -tiotropim bromide-olodaterol (Stiolto Respimat) 2.5-2.5 mcg inhalation, inhale one puff into the lungs every 12 hours -potassium chloride 20 milliequivalents (mEq/ measurement) take one tablet two times a day with food -phosphorus (K Phos Neutral) 155-852-130 mg, take two tablets by mouth one time a day. Take with a full glass of water. On December 10, 2024, at 10:45 a.m., the surveyor observed RN-G administer R18's medication.	01760			

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01760	Continued From page 54 On December 11, 2024, at 1:11 p.m., the surveyor reviewed R18's prescriber order with RN-L. RN-L stated R18's potassium chloride had a different order than what was on R18's MAR and she would contact the pharmacy about the order. On December 11, 2024, at approximately 1:15 p.m., RN-L stated she thought there was one other order for R18. On December 11, 2024, at 1:20 p.m., RN-L stated R18's Stiolto was incorrect and was a medication error. On December 11, 2024, at 2:36 p.m., the surveyor received R18's "order clarification" from CNS-C which included: -Wes-Phos 250 Neutral tablets, take two tablets 500 mg by mouth twice daily, take with full glass of water. R18's record did not include a prescriber order for We-Phos to be taken with a few drops of water and turned into a paste, dated August 2, 2024. MANUFACTURER'S INSTRUCTION R17's December 1, 2024, through December 10, 2024, MAR included: -Fosamax 70 mg one tablet on time a week, with plain water, 8:00 a.m. R17's prescriber order dated December 9, 2024, included the above medication. The manufacturer's instruction for Fosamax dated August 15, 2023, noted take Fosamax first thing in the morning, at least 30 minutes before you eat or drink anything or take nay other medicine. If you take this medicine only once per	01760			

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01760	Continued From page 55 week, take it on the same day each week and always first thing in the morning. Take with a full glass (six to eight ounces) of plain water. Do not use coffee, tea, soda, juice, or mineral water. Do not eat or drink anything other than plan water. Do not crush, chew, or such on a Fosamax tablet. Swallow the tablet whole. For at least 30 minutes after taking Fosamax: do not lie down or recline, do not take any other medicine including vitamins, calcium, or antacids. On December 10, 2024, at 4:14 p.m., the surveyor reviewed the manufacturer's directions for R17's Fosamax with RN-L. RN-L stated she would reach out to R17's prescriber for complete directions for R17's Fosamax administration. FOLLOWING THE STEPS OF THE MEDICATION ADMINISTRATION PROCESS R2 On December 10, 2024, at 9:14 a.m., ULP-D stated she documented R2's medication as administered prior to administering R2's medication. R20 On December 10, 2024, at 7:53 a.m., ULP-D stated she had documented R20's medication as administrated and had left R20's medication with R20. ULP-D added R20 "preferred" we (ULPs) do it that way. ULP-D said you learn who you can leave medications with, you learn the "clients" and there was only one (resident) whose record noted you could leave medications with him. ULP-D added she would go back and check on R20. R17 On December 10, 2024, at 7:50 a.m., ULP-D stated R17 had five pills left on the table. ULP-D	01760			

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01760	Continued From page 56 added she would go back and check on her after "we do these ones [administer other medication]. ULP-D stated the staff who trained her told her you could leave medication with residents. ULP-D confirmed she had documented R17's medication as administered prior to ensuring R17's medication was administered. On December 10, 2024, at 11:18 a.m., CNS-C stated, the person (staff) setting up the medication should give the medication and documenting the medication administration after and not prior to medication administration. The licensee's Medication & Treatment Orders-Implementing policy dated August 15, 2024, noted, upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. The licensee's Medication & Treatment-Administration & Delegation policy dated August 15, 2024, noted the registered nurse must instruct the ULP on the following medication administration tasks before delegating the task to them: -the complete procedure of checking a resident's medication administration record (MAR) -the preparation of medication for administration -the administration of the medication to the resident -the documentation after assistance with medication reminder or medication administering, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered.	01760			

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01760	Continued From page 57 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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 one of four medication carts was secured (medication cart 200). 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 December 10, 2024, at 2:06 p.m., the surveyor observed unlicensed personnel (ULP)-H and ULP-K perform a narcotic count on medication cart labeled 200, which was positioned in the hallway next to the facility's dining room.	01880			

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01880	Continued From page 58 On December 10, 2024, at 2:07 p.m., the surveyor observed the 200-medication cart unsecured (unlocked) and no ULP within direct eyesight. On December 10, 2024, at 2:12 p.m., the surveyor and registered nurse (RN)-G observed the unsecured 200-medication cart. RN-G locked the 200-medication cart, while he stated the medication carts were to be locked when not in use. On December 10, 2024, at 2:26 p.m., clinical nurse supervisor (CNS)-C stated medication carts should be locked (secured) when not in use. The licensee's Medication Storage policy dated October 23, 2024, noted medications managed by [licensee] would be centrally stored to prevent diversion of medication by resident's or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications. Scheduled II drugs would be stored under a double lock system and stored separately from other medications. No further information was provided. 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	01890			

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01890	Continued From page 59 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 maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for four of four medication carts: 100, 200, 400, 300 & 500 (combined into one cart). In addition, the licensee failed to monitor for expired medication for one of ten residents (R10). Further, the licensee failed to ensure insulin pens were maintained bearing the original prescription label with legible information including 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 December 9, 2024, at 11:00 a.m., the surveyor and clinical nurse supervisor (CNS)-C reviewed the contents of the locked medication carts. CNS-C observed and confirmed the following: MEDICATION CART 100 TIME SENSITIVE MEDICATION -R3's opened timolol mateate 0.5% (high eye pressure) eye solution, dated October 12, 2024,	01890			

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01890	Continued From page 60 lacked expiration date -R4's opened prednisone 1% (inflammation) eye solution lacked the date the eye solution was opened or expiration date -R5's opened timolol maleate 0.5% eye solution lacked the date the eye solution was opened or expiration date PRESCRIPTION LABEL -R3's opened timolol mateate 0.5 % lacked the original prescription label with legible information to include resident name -R4's opened timolol mateate 0.5% lacked the original prescription label with legible information to include resident name -R5's opened timolol maleate 0.5%, lacked the original prescription label with legible information to include resident name MEDICATION CART 200 TIME SENSITIVE MEDICATION -R8's opened Anoro 62.5 microgram (mcg)/25 mcg (lung issues) inhaler lacked the date the inhaler was opened or expiration date -R8's opened fluticasone 500/50 mcg (prevent asthma attacks) inhaler lacked the date the inhaler was opened or expiration date -R9's opened timolol maleate 0.5% eye solution lacked the date the eye solution was opened or expiration date PRESCRIPTION LABEL -R8's opened Anoro, 62.5 inhaler lacked the original prescription label with legible information to include resident name -R8's opened fluticasone 500/50 inhaler lacked the original prescription label with legible information to include resident name MEDICATION CART 400	01890			

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01890	Continued From page 61 TIME SENSITIVE MEDICATION -R2's opened Advair Diskus 250/50 mcg (lung issues, asthma) inhaler lacked the date the inhaler was opened or expiration -R6's opened latanoprost 0.005% (eye pressure) lacked the date the eye solution was opened or expiration date PRESCRIPTION LABEL -R2 opened Advair 500/50 mcg inhaler lacked the original prescription label with legible information to include resident name -R7's opened Ventolin HFA inhaler lacked the original prescription label with legible information to include resident name MEDICATION CART 300/500 TIME SENSITIVE MEDICATION -R11's opened budesonide and femaotrol fumarate 80/4.5 inhaler lacked the date the inhaler was opened or expiration -R12's opened latanoprost 0.0005% eye solution opened date of December 9, 2024, lacked expiration date PRESCRIPTION LABEL -R11's opened budesonide and femaotrol fumarate 80/4.5 mcg inhaler lacked the original prescription label with legible information to include resident name. On December 9, 2024, at 11:38 a.m., CNS-C stated dating medications and ensuring medications were labeled correctly for residents was a widespread issue. CNS-C confirmed resident "cubbies" were not a substitute for resident's names. EXPIRED MEDICATION -R10's nystatin powder (yeast/fungal) expiration	01890			

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01890	Continued From page 62 dated March 25, 2023 Directly after this observation CNS-C stated they (licensee) "missed" R10's powder when the medication carts were monitored for expired medication. CNS-C removed the expired medication. The manufacturer's instructions for timolol mateate dated March 20, 2020, directed discard solution 28 days after opening the bottle. The manufacturer's instructions for prednisone eye solution dated October 2023, directed discard the bottle 28 days after opening, even if there was solution remaining. The manufacturer's instructions for Anoro Ellipta inhaler dated June 6, 2019, directed to safely throw away Anoro Ellipta in the trash six weeks after you open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler. The manufacturer's instructions for fluticasone dated January 2020, directed write the date you opened the pouch on the first line of the label and the "use by" date on the second line of the label. The "use by" date is one month after the date you opened the pouch. The manufacturer's instructions Advair dated January 2019, directed to write the date you opened the foil pouch in the first blank line on the label. write the "use by " date in the second blank line on the label. That date is one month after the date you write in the first line. The manufacturer's instructions for latanoprost dated February 1, 2023, directed to discard within	01890			

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01890	Continued From page 63 4 weeks of opening. The manufacturer's instructions for budesonide and femaotrol fumarate dated October 1, 2024, directed throw the inhaler when it reaches o, or if it had been three months since you last opened the foil pouch. INSULIN PENS On December 10, 2024, at 7:16 a.m., the surveyor observed registered nurse (RN)-G administer Lantus (long acting) insulin 100 milliliters (ml)/unit, 22 units to R16. RN-G stated he was not able to read the date R16's insulin pen was opened (dated) as the date had "smeared." RN-G said he could not figure out what 28 days was so he did not put an expiration date on the insulin pens. RN-G added the insulin pens expired in about 30 days, "I know that." RN-G stated he dated all of the insulin pens the same way. RN-G stated he administered insulin to the residents Monday through Friday and a ULP was trained to administer insulin on the weekends. RN-G stated opened insulin pens were kept in resident rooms in locked medication cabinets. RN-G confirmed opened insulin pens were not dated to include an expiration date as required. The manufacturer's instructions for Lantus dated March 2020, directed after 28 days, throw your opened Lantus pen away, even if it still had insulin in it. The licensee's Medication Storage policy dated October 23, 2024, noted medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).	01890			

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01890	Continued From page 64 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940			

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01940	Continued From page 65 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R18) who had treatments managed by the facility. 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: During the entrance conference on December 9, 2024, at approximately 10:35 a.m., clinical nurse supervisor (CNS)-C confirmed the licensee provided treatment and therapy services to residents. R18's diagnosis included chronic respiratory failure/chronic obstructive pulmonary disease (COPD, chronic inflammatory lung disease that causes obstructed airflow from the lungs), bone pain, hypokalemia (low potassium), hypothyroid, hypercholesterolemia (high cholesterol), major depressive disorder, and anxiety. R18's record did not include a service plan. R18's prescriber order dated February 16, 2024, included: -edema wear: Jobst compression stocking put on	01940			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER KEYSTONE BLUFFS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2528 TRINITY ROAD DULUTH, MN 55811		
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01940	Continued From page 66 in a.m. (morning) and off at p.m. (evening). R18's prescriber order dated June 7, 2024, included: - OT (occupation therapy) needs use of lymphedema pumps to help manage chronic lymphedema in RLE (right lower extremity) that has improved with lymphedema therapy and mild compression. R18's assessment dated December 10, 2024, included: -resident has been observed taking on/off tubigrips, needs help putting on -lymphedema pumps provided by out patient OT with service on service plan for daily use on right leg. R18's RTask (computer system used) dated November 24, 2024, included: -place lymphedema pump on right leg two days per week for 30 minutes per time max. The goal: the work up to 30 minutes per day. R18's service recap summary dated December 1, 2024, through December 10, 2024, included: -edema wear a.m. -edema wear a.m., (Tuesday/Thursday) -edema wear p.m. On December 10, 2024, at 10:45 a.m., the surveyor observed registered nurse (RN)-G attempt to start R18's lymphedema leg pump. R18's record did not include evidence of an individualized treatment management plan for R18's to include, a statement of type of service provided. On December 11, 2024, at 8:21 a.m., CNS-C	01940			

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01940	Continued From page 67 stated R18's service plan was not signed. On December 11, 2024, at 11:19 a.m., CNS-C stated getting service plans signed was a "big problem." CNS-C said some of the resident's refuse to sign the service plans. CNS-C confirmed R18's record lacked a service plan to include treatment or therapy services provided. The licensee's Treatment & Therapy Management Plan policy dated August 15, 2024, noted for each resident at facility receiving management of ordered or prescribed treatments or therapy services, that facility would prepare and include in the service plan a written statement of the treatment or therapy services that would be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	01950			

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01950	Continued From page 68 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure instructions, specified in writing for each resident, and documented those instructions in the resident's record for three of three residents (R10, R14, R16) receiving treatments. 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 December 9, 2024, at approximately 10:40 a.m., clinical nurse supervisor (CNS)-C stated the licensee used "both" types of blood glucose (BG) monitoring (continuous/ less invasive and fingerstick monitoring). R10 R10's diagnoses included diabetes, retention of urine, chronic kidney disease (kidneys are damaged and can't filter blood effectively) and depression.	01950			

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01950	Continued From page 69 R10's service plan dated October 3, 2024, indicated R10 received the following services: - BG monitoring: four times per day -weight two days a week. R10's prescriber's order dated May 31, 2024, included: -FreeStyle Libre 2 Sensor kit, apply Freestyle Libre 2 senor once every 14 days (continuous glucose monitoring, replacement for fingerstick monitoring) -BG three times daily -BG daily -weight, two days a week. R10's service recap summary dated December 1, 2024, through December 10, 2024, included: -BG monitoring four times daily. R10's RTask (computer system used) medical monitoring, weights instructions dated August 13, 2024, included: -monitor for an increase or decrease in resident's weight. Notify MD (medical doctor) as needed. Wheelchair weight 60.6, no pedals, wheelchair weight 65 pounds with pedals. On December 10, 2024, at approximately 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-J use a Sara Steady (transfer assist machine) to transfer R10 from recliner into bathroom. R10's service plan had noted weights were done twice a week, however R10's weights were not currently monitored. On December 11, 2024, at 12:10 p.m., the surveyor reviewed R10's record with registered nurse (RN)-N, who stated R10's record did not	01950			

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01950	Continued From page 70 include instructions for ULPs for when to contact nursing about R10's weight; to monitor, yes, but not when to report. In addition, RN-N stated R10's record did not include what type of BG meter was used for R10's BG monitoring. R14 R4's diagnoses included diabetes. R14's service plan dated July 30, 2021, did not include BG monitoring. R14's service recap dated December 1, 2024, through December 10, 2024, included: -if blood sugar is below 70 and client (resident) is alert and able to swallow, give a glass of juice. Recheck blood sugar in five minutes before escorting to meal. Then escort to the dining room and ask kitchen staff to give them their meal. If at HS (hour of sleep), give a full sandwich and call nurse if BG does not go up over 100. If blood sugar is greater than 400, then give two glasses of water, limit sweets and notify nurse. On December 10, 2024, at 6:55 a.m., RN-G placed a BG testing strip into a BG meter, cleansed R14's middle finger on left hand, used a lancet to collect a BG sample and received a BG level of 179. R14 told RN-G "I thought we were not doing that [BG] monitoring anymore." R14's prescriber order dated December 9, 2024, included: -d/c (discontinue) scheduled BG checks -BG check as needed for symptoms of hypoglycemia (low blood sugar). R14's record lacked specific instructions to include which type of BG monitoring system was in place.	01950			

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01950	Continued From page 71 On December 10, 2024, at 4:28 p.m., the surveyor reviewed R14's record with RN-L. RN-L stated R14's record did not note which type of BG monitoring was used. RN-L said there were other resident records that did not include the type of BG monitoring system used. RN-L added, was one resident that had a sensor for BG monitoring, and she (RN-L) was monitoring BG one day and that resident had to tell her he had a sensor for BG monitoring, and he did not need to have his finger poked for BG monitoring. RN-L stated that would be a good thing to include in resident records. R16 R16's diagnosis included diabetes. R16's service plan dated June 5, 2023, indicated R16 received BG monitoring twice a day. On December 10, 2024, at 7:11: a.m. the surveyor observed RN-G cleanse R16's left ring finger, insert a BG testing strip into a BS machine, use a lancet to obtain a BG reading of 127. RN-G stated he monitors R16's BG during the week. RN-G said R16's record did not include specific instructions to include what type of BG monitoring system was used. RN-G added he just knew which type of used for each resident. On December 10, 2024, at 7:23 a.m., CNS-C stated she was not sure if resident records included type of BG monitoring system used in resident records. On December 11, 2024, at 12:16 p.m., the surveyor reviewed R10's and R16's record with CNS-C, who confirmed resident records lacked specific instructions, as required. Additionally,	01950			

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01950	Continued From page 72 CNS-C stated she could not do it (make corrections) herself, and that she needed help from the other nurses. The licensee's Treatment & Therapy Management Plan policy dated August 15, 2024, noted [licensee] would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -documentation of specific resident instructions relating to the treatments or therapy administration -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced	01960			

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01960	Continued From page 73 by: Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed for two of three residents (R10, R17) with health monitoring managed by the provider. 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 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: R10 R10's diagnoses included diabetes, retention of urine, chronic kidney disease (kidneys are damaged and can't filter blood effectively) and depression. R10's service plan dated October 3, 2024, indicated R10 received the following services: -blood pressure, pulse, respirations, temperature: monthly -weight: two times a week. R10's prescriber's order dated May 31, 2024, included: -lung sounds: five days a week -oxygen monitoring: (SpO2) three times per day -weight: two times a week -edema wear: apply Tubi-grip. Do not use compression stockings, a.m., (morning) p.m., (evening).	01960			

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01960	Continued From page 74 On December 10, 2024, at approximately 6:45 a.m., the surveyor observed unlicensed personnel (ULP)-J use a Sara Steady (transfer assist machine) to transfer R10 from recliner into bathroom. R10's service recap summary dated December 1, 2024, through December 10, 2024, was lacking: -tubi-grips (compression type of stocking) -lung sounds -SpO2 monitoring (level of oxygen in the blood) -weights two days per week. On December 11, 2024, at 12:10 p.m., registered nurse (RN)-N stated she did not "see" the orders for R10's tubi grips, lung sound monitoring, SpO2 monitoring and weights two times per week on R10's prescriber order. RN-N confirmed R10's prescriber ordered treatments were not completed as ordered. R17 R17's diagnoses included atrial fibrillation (A-fib- an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), chronic systolic congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (high blood pressures/ HTN) and chronic kidney disease. R17's record lacked a service plan. On December 10, 2024, at 7:24 a.m., the surveyor observed ULP-D review R17's medication administration record (MAR) and remove R17's medication, one at a time, and put all the medications listed on R17's December MAR into a medication cup.	01960			

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01960	Continued From page 75 R17's prescriber order dated December 9, 2024, included: -weight yourself daily and keep record. Call MD (medical doctor) if weight gain of two pounds per day or five pounds in a week. On December 11, 2024, at 1:57 p.m., RN-L stated she did not see the prescriber's order for R17's daily weights. RN-L confirmed R17's prescriber ordered treatment was not completed as ordered. On December 11, 2024, at 12:16 p.m., the surveyor reviewed R10's and R17's records with clinical nurse supervisor (CNS)-C. CNS-C stated she could not do it (make corrections) herself, and confirmed R10 and R17 did not receive prescriber ordered treatments. The licensee's Medication & Treatment Orders Implementing policy dated August 15, 2024, noted upon receipt of a medications and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care	02310			

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02310	Continued From page 76 standards. This MN Requirement is not met as evidenced by: The licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for one of two residents (R18) with an oxygen tank. 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 December 10, 2024, at 10:45 a.m., the surveyor observed registered nurse (RN)-G administer a cup of medication to R18. R18 was lying on a bed wearing a nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen). R18's oxygen tubing was attached to an operating oxygen concentrator. R18 stated there were some oxygen tanks in her closet. On December 10, 2024, at 10:50 a.m., the surveyor and RN-G observed six secured oxygen tanks in a storage rack and one oxygen tank not secured laying on the top of a pile of clothing. RN-G stated he did not know R18 stored oxygen in her closet. RN-G added he had never seen R18 use oxygen when outside of her room.	02310			

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02310	Continued From page 77 Directly after the above observation RN-G secured the oxygen tank, as he placed the oxygen tank into an oxygen rank. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. The licensee's Oxygen policy dated September 12, 2024, noted, oxygen cylinders and vessels would be kept in a well-ventilated area (not in closets, behind curtains, or other contained space.). The small amount of oxygen gas that is continually vented from these units can accumulate in a confined space and become a fire hazard. Oxygen cylinders and vessels much remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced	02320			

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02320	Continued From page 78 by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards by three of three employees, (unlicensed personnel (ULP)-D, ULP-E, registered nurse (RN)-G) during medication administration for R18. In addition, the licensee failed to ensure a care plan was followed by three of three employees, (ULP-D, ULP-E, RN-G) for R18. 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: R18's diagnosis included chronic respiratory failure/chronic obstructive pulmonary disease (COPD, chronic inflammatory lung disease that causes obstructed airflow from the lungs), bone pain, hypokalemia (low potassium), hypothyroid, hypercholesterolemia (high cholesterol), major depressive disorder, and anxiety. R18's service plan dated December 10, 2024, included medication administration. R18's prescriber orders dated October 12, 2024, included: -diazepam (anxiety) take 2.5 milligrams (mg) four times per day -torsemide (excess fluid) 20 mg, by mouth every	02320			

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NAME OF PROVIDER OR SUPPLIER KEYSTONE BLUFFS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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
02320	Continued From page 79 morning -aspirin (heart health) 81 mg daily -cetirizine (antihistamine/ allergy symptoms) 10 mg one time a day -clopidogrel (lowers risk of stroke) 75 mg one daily -guaifenesin (Mucinex (cold/allergies) 600 mg, take two tablets, every 12 hours. Take with a full glass of water. DO NOT CRUSH -magnesium 400 mg (supplement) 400 mg twice a day (breakfast and supper) -methimazole (thyroid) 5 mg, one tablet once daily -paroxetine (antidepressant) 10 mg take one every morning -phosphorus (K Phos Neutral/supplement) 155-852-130 mg tablet, take two tablets by mouth one time a day, take with a full glass of water -potassium chloride (treat or prevent low level of potassium in body) take one tablet, 20 milliequivalents (mEq/ measurement) two times a day with meals. May add a couple drops of water to turn into paste and administer with pudding/applesauce. Do not crush. -prednisone (inflammation) 10 mg once daily with food -amoxicillin (infection) 500 mg once daily -senna-docusate (Senna S/ laxative-stool softener) 50-8.6 mg, take one tablet by mouth one time a day, hold for loose stool. MEDICATION ADMINISTRATION On December 10, 2024, at 8:49 a.m., the surveyor observed two unidentified ULPs (not medication trained) entering R18's room. ULP-D asked the two unidentified ULPs if they would administer R18's medication. ULP-D added "I'll come knock on the door when I have them [medication] ready." ULP-D stated she could not enter R18's room because she was allergic to	02320			

Minnesota Department of Health

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02320	Continued From page 80 cats. ULP-D added R18 had a cat. On December 10, 2024, at 8:57 a.m., ULP-D had R18's medication prepared, however the two unidentified ULPs had exited R18's room. ULP-D stated she would call ULP-E to administer R18's medication. ULP-D used a handheld walk-talkie and summoned ULP-E to R18's room. On December 10, 2024, at 9:02 a.m., ULP-D handed R18's two prepared medication cups to ULP-E. ULP-E stirred the medication. ULP-E told ULP-D R18 would not take the medication as the medication had not dissolved. On December 10, 2024, at 9:05 a.m., ULP-E handed R18 a medication cup. R18 "tasted [put her tongue into the medication cup] and stated, "if not salty, it's not the right pill." R18 stated she would not eat "chunks" in it [medication]. " R18 stated, (name) does not know how to transcribe my pills [enter medication from prescriber order to MAR). On December 10, 2024, at 9:07 a.m., ULP-E returned the medication cups to ULP-D. On December 10, 2024, at 9:25 a.m., ULP-D stated she did not destroy R18's medication yet. ULP-D added she would wait, until she got directions of what to do with R18's medication. On December 10, 2024, at 10:45 a.m., the surveyor observed RN-G administer R18's medication. On December 10, 2024, at 10:50 a.m., RN-G stated he checked R18's MAR to make sure he knew what he was giving (medication) to R18. The surveyor asked how RN-G could tell what	02320			

Minnesota Department of Health

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02320	Continued From page 81 was in the medication cup as some of the medication was mixed with water. RN-G stated he should not be doing that (giving R18 her medication). RN-G said all staff should give the medication they (staff) set up. RN-G added he did not like to give medication someone else set up. On December 10, 2024, at 11:18 a.m., clinical nurse supervisor (CNS)-C stated, the person (staff) setting up the medication should give the medication and document the medication administration. CARE PLAN DIRECTION R18's Individualized Medication Management Plan dated December 10, 2024, included: -resident has recent reports of not receiving medications as ordered. Care plan updated for two staff to be present for medication administration in response to this concern. Resident reports swallowing difficulty with medications, necessitating extra time to take medication one at a time. R18's medication administration record (MAR) dated December 1, 2024, through December 10, 2024, included: -diazepam take 2.5 mg four times per day. TWO STAFF TO ADMINISTER ALL MEDS (medication) TO RESIDENT -torsemide 20 mg, by mouth every morning. TWO STAFF TO ADMINISTER ALL MEDS TO RESIDENT -aspirin 81 mg by mouth daily. *** RESDIENT NOT SPLIT OR CRUSH*** TWO STAFF TO ADMINISTER ALL MEDS TO RESIDENT -cetirizine 10 mg one time a day. TWO STAFF TO ADMINISTER ALL MEDS TO RESIDENT -clopidogrel 75 mg one daily. TWO STAFF TO ADMINISTER ALL MEDS TO RESIDENT	02320			

Minnesota Department of Health

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02320	Continued From page 82 -guaifenesin 600 mg, take two tablets, two times a day. -magnesium 400 mg. Take one tablet by mouth two times a day (breakfast and supper) CRUSH AND MIX WITH YOGURT OR PUDDING. NO APPLESAUCE. -paroxetine 10 mg take one every morning, TWO STAFF TO ADMINISTER ALL MEDS TO RESIDENT -phosphorus give two tablets by mouth one time a day with meals. May add a couple drops of water to turn into paste and administer with pudding. Do NOT crush. TWO staff to administer all medication to resident -potassium chloride, take two tablets by mouth one time a day with breakfast AND one tablet one time a day with supper. May add a couple drops of water to turn into paste and administer with pudding. Do NOT crush. TWO staff to administer all meds to resident. -prednisone one tablet one time a day with food -stool softener/laxative 50-8.6 mg, take one tablet by mouth one time a day, hold for loose stool. TWO STAFF TO ADMINISTER ALL MEDS TO RESIDENT. On December 10, 2024, at 9:05 a.m., the surveyor observed ULP-E enter and attempt to administer R18's medication. There were not two staff present for R18's medication administration. On December 10, 2024, at 10:45 a.m., the surveyor observed RN-G enter R18's room with an unidentified ULP. R18 told the unidentified ULP to leave the room, and the ULP left the room. R18 looked at the surveyor and stated, "you are here". The surveyor told R18 that the surveyor was there to observe only and was not a staff member. RN-G administered R18's medication. There were not two staff present for	02320			

Minnesota Department of Health

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02320	Continued From page 83 R18's medication administration. On December 10, 2024, at 11:20 a.m., CNS-C stated care plans should be followed. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy reviewed January 3, 2022, noted staff would document each task immediately after that task had been performed. Documentation would follow [professional standards for documentation, including the requirement that entries must be: -legible -dated with the time of entry -authenticated with the name and title of the person making the entry. When initials are used by persons making entries in the resident record, the person will authenticate initials with a full signature and title. The signature and title may be included on the same document -staff would use only approved health care abbreviation identified by the RN and agency. The licensee's Resident Records policy reviewed January 3, 2022, noted record entries would be legible, permanently recorded, dated, and signed by the person making the entry. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties. No further information was provided.	02320			

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02320	Continued From page 84	02320			
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of two residents (R10) was treated with dignity and respect when R10's urinary drainage bag was exposed in common areas. 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: R10's diagnoses included obstructive and reflux uropathy (urine flow blocked /partially or completely), retention of urine (bladder not emptying), chronic kidney disease (loss of kidney function). R10's Service Plan dated October 3, 2024, indicated R10 received the service: empty urinary catheter (a tube inserted into the bladder,	02350			

Minnesota Department of Health

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02350	Continued From page 85 allowing urine to drain freely) drainage bag four times daily. On December 10, 2024, at approximately 6:45 a.m., the surveyor observed R10 sitting in a recliner and a catheter bag was seen in a basin near R10. Unlicensed personnel (ULP)-J used a Sara Steady (transfer assist machine) to transfer R10 from recliner into bathroom. ULP-J had a catheter leg bag in her hand. On June 6, 2022, at approximately 8:00 a.m., the surveyor observed R10 in a wheelchair self-propelling the wheelchair out of the facility's dining room. The surveyor observed R10's foley catheter leg drainage bag attached to R10's lower leg. R10's catheter bag was not covered (kept private) and the bag was approximately half full of yellow colored urine. The surveyor observed approximately ten residents sitting in the dining room having breakfast. On December 10, 2024, at 11:14 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated R10 usually had pants on, and both added, "we" (licensee) had covers for "regular" (bed bags). CNS-C and LALD-A said R10's regular urinary drainage bag got a hole in it, R10 normally did not wear a leg bag. On December 10, 2024, at 2:03 p.m., R10 stated the licensee usually have a cover for his urinary drainage bag. R10 added he thought the cover for the catheter drainage bag was in the wash. R10 stated he was "a little paranoid" about the leg bag being visible. On December 10, 2024, at 2:25 p.m., CNS-C stated she was not sure "it" would bother her,	02350			

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02350	Continued From page 86 seeing a catheter urine bag while in the dining room. CNS-C confirmed R10's urinary drainage bag could be a dignity issue for R10. The licensee's Person-Centered Care policy dated December 4, 2024, noted [licensee] was committed to provide person-centered care that emphasized the dignity, independence, and unique preferences of each resident. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to be treated with courtesy and respect. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350			
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure resident's personal health and medical information was kept	02430			

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02430	Continued From page 87 private. This had the potential to affect all residents residing at the assisted living facility. 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: NARCOTIC LEDGERS On December 9, 2024, at approximately 12:05 p.m., during a tour of the facility with licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-C, and registered nurse (RN)-B the surveyor observed narcotic ledgers positioned on the top of medication carts 100, 300, 400, and 500, in a commons area, next to the facility dining room. The narcotic ledgers included names of residents, medications, counts of medications, and time medications were administered. The narcotic ledgers were not secure. On December 9, 2024, at 12:09 p.m., LALD-A and CNS-C stated they had never seen narcotic books (ledgers) locked up, not at any of the licensee's facilities. RN-B stated no private information should be in common's area, and the narcotic books should be locked up (secured). MEDICATION LABELS On December 11, 2024, at 9:09 a.m., the surveyor observed three empty medication containers on top of the 400-medication cart positioned outside of the dining area in which five residents were seated. The surveyor observed no	02430			

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02430	Continued From page 88 staff members in the area, down either hallway. The prescription bottles observed: -R17's hydroxychloroquine 200 milligrams (mg), (malaria, lupus, rheumatoid arthritis) take one tablet by mouth one time a day -R22's sodium chloride one gram (gm), (supplement/electrolyte) take one tablet one time a day -R6's polyethylene glycol 3350 take 17 gm (bowel health) once daily. On December 11, 2024, at 9:13 a.m., unlicensed personnel (ULP)-K walked to the 300/500 medication cart. The surveyor asked ULP-K if the empty medication container should be positioned on the top of the 400-medication cart? ULP-K stated the medication containers should not be left on top of the cart. ULP-K added "normally" the empty containers were taken to the medication refill area and disposed of there. ULP-K said she would lock up the medication bottles, but she did not have keys to the 400-medication cart. ULP-K added the medication labels, information, should be scribbled out or the entire label removed if possible. On December 11, 2024, at approximately 11:30 a.m., CNS-C stated it was not "ok" to have medication containers on top of the medication carts if the medication was labeled with resident information (names of resident, medication name, dosage, time to be given). On December 11, 2024, at approximately 3:00 p.m., RN-B stated the prescription labels should have been scribbled out or removed from the medication bottles. The licensee's Resident Record- Access & Storage policy dated October 22, 2024, noted the	02430			

Minnesota Department of Health

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02430	Continued From page 89 resident record would be kept in a secure location within their respective site. All information in the resident record is confidential; all staff are responsible to make sure confidentiality is maintained for all resident records and information. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02430			



Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: 12/11/24
Time: 11:00:00
Report: 1016241185

Food and Beverage Establishment Inspection Report

Page 1

Location:

Keystone Bluffs
2528 Trinity Road
Duluth, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038246
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2187272800
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-900 Protecting Clean Items

4-904.11B

MN Rule 4626.0965B Present clean knives, forks, and spoons that are not prewrapped in trays and holders so that only the handles are touched by employees or consumers.

SILVERWARE WAS BEING STORED HANDLES DOWN. STAFF INVERTED SILVERWARE DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit

Location: DISH WASHER

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler

Temperature: 35 Degrees Fahrenheit - Location: ONIONS

Violation Issued: No

Process/Item: Walk-In Freezer

Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN

Violation Issued: No

Process/Item: Walk-In Cooler

Temperature: 35 Degrees Fahrenheit - Location: LEMONS

Violation Issued: No

Type: Full
Date: 12/11/24
Time: 11:00:00
Report: 1016241185
Keystone Bluffs

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Hot Holding
Temperature: 147 Degrees Fahrenheit - Location: POTATOES
Violation Issued: No

Process/Item: Hot Holding
Temperature: 141 Degrees Fahrenheit - Location: SAUSAGE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 141 Degrees Fahrenheit - Location: GREEN BEANS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 138 Degrees Fahrenheit - Location: CHILI
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	1

COMMENTS:

DISCUSSED REHEATING REQUIREMENTS FOR HOT HOLDING

DISCUSSED RAPID COOLING STRATEGIES

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

Type: Full
Date: 12/11/24
Time: 11:00:00
Report: 1016241185
Keystone Bluffs

Food and Beverage Establishment Inspection Report

Page 3

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016241185 of 12/11/24.

Certified Food Protection Manager: PAUL W. LUKEN

Certification Number: FM118980 Expires: 09/12/26

Signed: _____

PAUL W. LUKEN
HEAD CHEF

Signed:  _____

Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us