DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 27, 2023

Licensee
Keystone Place At Lavalle Field
14602 Finale Avenue North
Hugo, MN 55038

RE: Project Number(s) SL32045015

Dear Licensee:

On April 25, 2023, the Minnesota Department of Health completed a follow-up survey of your agency to determine if orders from the February 10, 2023, survey were corrected. This follow-up survey verified that the agency is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

Electronically Delivered

March 15, 2023

Licensee
Keystone Place at Lavalle Fields
14602 Finale Avenue North
Hugo, MN 55038

RE: Project Number(s) SL32045015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 10, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jess Schoenecker, Supervisor
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-7389 Fax: / 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL 32045015-0 On February 6, through February 9, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 90 active residents; 66 receiving services under the Assisted Living with Dementia Care license. On February 9, 2023, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living	0 250		

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0 250	Continued From page 2 facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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:	0 250		

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0 250	Continued From page 3 During the entrance conference on February 6, 2023, at 10:15 a.m., licensed assisted living director (LALD)-D and director of nursing (DON)-A stated they were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living with Dementia Care License, section titled Official Verification of Owner or Authorized Agent, (page five and six of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04	0 250		

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0 250	Continued From page 4 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by LALD-D on June 1, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of May 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) conducting and handling background studies on employees; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (4) medication and treatment management; (5) delegation of tasks by registered nurses or	0 250		

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0 250	Continued From page 6 licensed health professionals; and (6) supervision of unlicensed personnel performing delegated tasks. On February 9, 2023, at 2:15 p.m., LALD-D and DON-A confirmed the licensee provided assisted living with dementia care but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0580, 0630, 0680, 0730, 0780, 0790, 0800, 0810,0900, 0970, 1060, 1290, 1440, 1620, 1700, 1710, 1730, 1790, 1830, 1890, 1920, 1940, 1970, 2040, 2110, 2170, and 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management	0 580		

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0 580	Continued From page 7 must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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) 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 the residents). The findings include: On February 6, 2023, at approximately 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated the licensee was aware of the QMP requirement but one had not been developed or implemented. LALD-D stated the licensee provided ongoing improvement as areas were identified, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's 2.31 Quality Management Project (QMP) policy dated April 19, 2022, indicated a QMP would be implemented and documented. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 580		

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0 580	Continued From page 8 (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) with required content for all identified independent living 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: R2 signed the licensee's Assisted Living Contract - Independent on November 11, 2022.	0 630		

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0 630	Continued From page 9 R2's record lacked an IAPP developed and implemented by the licensee. On February 6, 2023, at 10:00 a.m. during the entrance conference, licensed assisted living director (LALD)-D provided the licensee's Current Resident Roster: State Evaluations which listed all residents who resided at the facility. There were 24 residents who were identified as not receiving services (commonly referred to as independent living) and were identified by an "X," in the column labeled, "Housing Only, No services." On February 6, 2023, at approximately 2:05 p.m., director of nursing (DON)-A indicated the licensee was not aware an IAPP was required to be developed and implemented for residents who were identified as independent living. DON-A stated an IAPP was not developed for any identified independent living resident. The licensee's 6.05 Individual Abuse Prevention Plan policy dated April 19, 2022, read, "The facility will develop and implement an individualized abuse prevention plan for each vulnerable adult." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	0 680		

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0 680	Continued From page 10 (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. (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 develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, and visitors to 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) 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	0 680		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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0 680	Continued From page 11 of the residents). The findings include: On February 6, 2023, at approximately 11:30 a.m., licensed assisted living director (LALD)-D provided a binder and indicated the contents were the licensee's EPP. The licensee's undated EPP lacked: -specific vulnerabilities/risk assessments; -annual updates; -resident plan quarterly review; -EPP collaboration; -EPP policies and procedures (P/P) based on the risk assessment and communication plan; -EPP P/P for tracking staff and patients, evacuation, sheltering, medical documents, volunteers, arrangement with other facilities, and roles under a waiver declared by secretary; -names and contact information; -emergency officials contact information notifications; and -emergency prep training and testing as required by Appendix Z. On February 9, 2023, at approximately 11:05 a.m., LALD-D acknowledged the licensee's EPP lacked the above listed required content. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated April 19, 2022, indicated the licensee's EPP would include all required elements of appendix Z. Additionally, the plan would be in writing and reviewed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights;	0 730		

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0 730	Continued From page 13 (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure records included documentation of services provided as identified in the service plan for two of five residents (R3, R4). 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 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: R3 On February 7, 2023, at 9:45 a.m., surveyor observed unlicensed personnel (ULP)-J apply compression socks and other personal cares in the bathroom. R3 admitted to licensee for services on July 22, 2020. R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes,	0 730		

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0 730	Continued From page 14 obesity, and reduced mobility. R3 received assistance with personal cares, medication and treatment management, mobility, homemaking, and laundry. R3's Task Administration Record (TAR) dated January 2023, lacked documentation of services provided on the following dates: -January 1-31, 2023, at various times of each day. R4 On February 7, 2023, at 8:15 a.m., surveyor observed ULP-I administer medications to R4, then escort R4 to the dining room table for another ULP to serve breakfast. R4 admitted to licensee for services on March 7, 2022. R4's medical record included diagnoses of type II diabetes, multiple sclerosis (disease of the brain and spinal cord), legal blindness, and atrial fibrillation (abnormal heart rhythm). R4 received assistance with personal cares, medication and treatment management. R4's TAR dated January 2023, lacked documentation of services provided on the following dates: -January 1-6, 8-18, 20-27, 29-31, 2023, at various times of each day. On February 9, 2023, at 1:20 p.m., director of nursing (DON)-A indicated the blanks noted on the TAR would indicate the ULPs have not documented on services they provided. The licensee's 7.20 Medication & Treatment orders policy dated April 19, 2022, a resident's	0 730		

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0 730	Continued From page 15 medication administration record or TAR would be audited regularly by licensed nurse or designee for documentation compliance. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) 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; (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	0 780		

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0 780	Continued From page 16 by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected in the resident apartment unit 201 so that the actuation of one alarm causes all alarms in the unit to actuate. This deficient condition had the ability to affect apartment unit 201. 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 a facility tour on February 8, 2023, at approximately 12:30 p.m., with the Facilities Director (FD)-K, survey staff observed that the one-bedroom resident apartment unit 201 had a bedroom smoke alarm that did not sound at the activation of the living room smoke alarm. Smoke alarms are required to be interconnected to sound throughout the unit for notification. This deficient condition was visually verified by FD-K accompanying the tour. On February 8, 2023, at approximately 4:45 p.m., during the exit interview, the licensed assisted living director (LALD)-D and the FD-K acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 780		

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0 780	Continued From page 17 (21) Days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide portable fire extinguishers that were properly serviced. This deficient condition had 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 a facility tour on February 8, 2023, between	0 790		

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0 790	Continued From page 18 approximately 10:00 a.m. and 3:00 p.m., with the Facilities Director (FD)-K, survey staff observed the following: -The portable fire extinguishers throughout the facility lacked current records to show compliant with the annual service requirements. The findings were evident as the tags on the extinguishers were consistently marked with the last service date of 12/2020. -The portable fire extinguishers throughout the facility were tagged with a red stamp that showed the extinguishers were due for the 6-year service. -The portable fire extinguisher gauge in the elevator equipment room with the needle indicated to be "recharged". These deficient conditions were visually verified by FD-K accompanying on the tour. On February 8, 2023, at approximately 4:45 p.m., during the exit interview, the licensed assisted living director (LALD)-D and the FD-K acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800		

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0 800	Continued From page 19 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, 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 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 a facility tour on February 8, 2023, between the hours of 10:00 a.m. and 3:00 p.m., with Facilities Director (FD)-K, survey staff observed the following: 1. The outside of the ground-level exit stairway B and the garage level of the elevator exit egress walkways lacked snow removal. As these paths of egress are labeled with an EXIT sign on top of the exit doors, they are required to be maintained and be clear of obstruction completely to a street or other public way to allow for proper exit in the event of an emergency. 2. The stairway exit door on the ground level exit	0 800		

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0 800	Continued From page 20 of stairway A to the exterior was incorrectly posted with a "Not an EXIT" on an 8.5 by 11-inch typed-up sign. 3. Excessive Storage: -The stairway B refuge area and path of egress were not properly maintained free of obstructions to allow for a proper exit. Survey staff observed these areas used to store commercial kitchen equipment, large plastic containers, and medical equipment. -The sprinkler riser room had accumulated excessive storage that restricted ready access to the fire suppression system components. The system is required to be maintained and clear of obstructions to allow for the sprinkler system to be accessible. - The mechanical room located across from Room 222 next to the North Star room was used for storage obstructing access to building equipment. The mechanical room areas around the equipment must be maintained free and clear of obstruction for necessary functioning of and access to building equipment (electrical, heating/ventilation/air conditioning, etc.). 4. The electrical power strips were utilized incorrectly in the storage areas with an office desk behind the "Happy" pub and in resident unit 104. In the resident unit 104, survey staff observed three power strips indirectly plugged into each other. These power strips were not connected directly to wall outlets and had multiple power strips indirectly connected to each other and extension cords were used. Improper use of power strips and the use of extension cords pose potential electrical fire hazards from overloading the circuits. 5. Fire-Rated Doors	0 800		

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0 800	Continued From page 21 -The sprinkler riser room fire-rated door on the garage-level floor failed to be maintained in the closed position to secure and maintain the integrity of the room and the garage-level floor. Survey staff observed the door was in the opened position with a door wedge. In addition, the sprinkler riser system lacked chains to secure in-place the valves to prevent tampering and must be reviewed with the administrative authority to prevent access by unauthorized individuals. -The garage-level floor building storage fire-rated door failed to close and positively latched. Survey staff observed the self-closer door hardware missing from the fire-rated door. 6. Electrical panels inside memory care resident unit units 4, 7, 14, 17, and 22 were unlocked and accessible to the residents. The FD-K stated that the panels in the memory care residents were supposed to be locked and were unlocked for recent repairs of the PTAC units and they forgot to re-lock the panels again. 7. A space heater was observed in the memory care resident unit 4 but was not currently in use. The finding was evident as the FD-K stated that he had temporarily used it due to the repair of the heating PTAC unit in the room and forgot to remove it. The finding was confirmed as the FD-K removed the space heater immediately to storage at the time of the tour. 8. The rain downspout pipe located in the memory care courtyard was loose and disconnected from the ground storm pipe to allow for rainwater/snow melt to be conveyed to the proper disposal. 9. The concrete slab walkway next to the disconnected rain downspout and located near	0 800		

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0 800	Continued From page 22 the exit door had water intrusion damage creating tripping hazards in the means of egress to the public way. The finding was evident as there was a change in elevation between the concrete slab walkways due to long exposure from water intrusion through freeze and thaw compromising the integrity of the walkways. These deficient conditions were visually verified by FD-K accompanying the tour. On February 8, 2023, at approximately 4:45 p.m., during the exit interview, the licensed assisted living director (LALD)-D and the FD-K acknowledged the above finding. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 23 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on documentation, interview, and observation, the licensee failed to maintain a current and an accurate facility floor plan layout and the required resident and employee training on fire safety and evacuation plan. This deficient condition had the ability to affect all staff, residents, 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 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:	0 810		

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0 810	Continued From page 24 On a facility tour on February 8, 2023, between approximately 10:00 a.m. and 3:00 p.m., with Facilities Director (FD)-K, survey staff observed incorrect room numbering on the posted evacuation floor plan layout throughout the facility. The findings were evident as the posted floor plan layout had resident room numbers that did not match with the resident room numbers posted next to the resident rooms throughout the facility. Evacuation floor plans must also be positioned to correlate the location of the reader and the layout of the facility (e.g., the north on the map should match the actual north). A document review and interview were conducted on February 8, 2023, at approximately 4:00 p.m. with the Licensed Assisted Living Director (LALD)-D and the FD-K, on the fire safety and evacuation plan, the required training, and evacuation drills for the facility, indicated the following: -Document review of the fire safety and evacuation training indicated that employees did not receive the required minimum training twice per year after new hire orientation. No fire safety and evacuation training records were available or provided for review. -Record review of the fire safety and evacuation drill records indicated that employees did not perform evacuation drills required that must be performed by employees twice per year per shift with at least one evacuation drill every other month. LALD-D did not provide evacuation drill records to show drills were performed. -Record review of resident training indicated that fire safety and evacuation annual training to residents who can self-assist in their evacuation on the proper actions to take in the event of a fire	0 810		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

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KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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0 810	Continued From page 25 or emergency. LALD-D did not provide documents to show this training was offered to the residents. On February 8, 2023, at approximately 5:00 p.m., these deficient conditions were verbally verified by LALD-D and FD-K during the review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the	0 900		

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0 900	Continued From page 26	0 900		

opportunity to identify a designated representative according to subdivision 3.

(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for one of one resident (R3).

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 began operations under their assisted living with dementia care facility license on August 1, 2021.

On February 6, 2023, at 4:03 p.m., licensed assisted living director (LALD)-D provided a blank assisted living lease/contract and indicated the contract was used by the licensee for all residents who received services by licensee.

R3 admitted July 22, 2020.

R3's record included a Residence and Services Agreement dated July 16, 2020. Additionally, R3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 900	Continued From page 27 Resident Move In Check List, dated July 16, 2022, indicating R3 received home care services. R3's record lacked an assisted living contract with required content. On February 8, 2023, at 11:00 a.m., LALD-D acknowledged the licensee's assisted living contract was not included in R3's record. LALD-D stated the licensee would need to provide the new assisted living contract to all residents with the old Residence and Services Agreement. The licensee's 1.05 Signing an Assisted Living Contract policy dated April 19, 2022, indicated when a prospective resident decided to move to licensee, a signed Assisted Living contract would be signed and received by the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 970		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 970	Continued From page 28	0 970		

contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all ninety (90) residents residing in the facility.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee converted to an Assisted Living with Dementia Care license on August 1, 2021.

The "[Licensee] Residence and Services Agreement", section 6, indicated the provider was not liable to residents by including the following language:
VI. PROPERTY RIGHTS AND OBLIGATIONS
-E. "Responsibility for Damages or Injury to Others. You are responsible for any injury or damage to persons or property caused by your acts or negligence."
-F. "Acts of Other Residents. You have chosen to live in a group setting with other residents and acknowledge that there is a risk of injury or illness or damage to your property from other residents."

On February 8, 2023, at 9:00 a.m., licensed assisted living director (LALD)-D confirmed the assisted living contract required residents to waive the facility's liability for health, safety, or personal property, and was included in all current residents' contracts. LALD-D indicated the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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0 970	Continued From page 29 contract would be updated to remove the wavier of liability. The licensee's 1.05 Signing an Assisted Living Contract policy dated April 19, 2022, indicated when a prospective resident decided to move to licensee, a signed Assisted Living Contract would be signed and received by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01060	Continued From page 30 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the Office of Ombudsman for Long-Term Care (OOLTC) if the resident has been relocated and has not returned to the facility within four days for one of one resident (R8) who had an emergency relocation. 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).	01060		

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KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01060	Continued From page 31 The findings include: R8 was admitted on January 5, 2023. R8's Progress Notes dated January 30, 2023, at 9:30 a.m., indicated R8 was transported and admitted to the hospital. R8's Progress Notes dated February 7, 2023, at 9:15 a.m., indicated R8 is still admitted to the hospital. R8's record lacked a notification as required: -In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. -The notice required under paragraph (b) must be delivered as soon as practicable to: -the resident, legal representative, and designated representative; and -for residents who receive home and community-based waiver services under chapter	01060		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01060	Continued From page 32 256S and section 256B.49, the resident's case manager. On February 07, 2023, at 12:20 p.m. director of nursing (DON)-A indicated the licensee was not aware of the required content of an emergency relocation notice and the licensee had not provided the notice to the Ombudsman when the emergency relocation was longer than four days. The licensee's 1.23 Emergency Relocation policy dated April 19, 2022, indicated the required written notice with the required content for an emergency relocation would be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=C	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01290	Continued From page 33 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living with dementia care license for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-B was hired on December 21, 2021. On February 7, 2023, at approximately 8:20 a.m., the surveyor observed ULP-B performing resident cares. ULP-B's employee record contained a background study clearance, affiliated with the licensee's former comprehensive license #32013, dated December 20, 2021. ULP-B's employee records lacked evidence of current, cleared background studies affiliated with the licensee's current assisted living with dementia care license #32045, effective August 1, 2021. On February 7, 2023, at 10:05 a.m., licensed assisted living director (LALD)-D indicated the background studies for all the licensee's	01290		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 34 employees were under the former comprehensive license versus the new assisted living license, and was unsure which license to use for employee background studies. The licensee's 4.02 Background Studies policy dated April 19, 2022, indicated licensee complies with all state regulations for pre-employment background checks/studies required for all employees. Additionally, all new hires must have a completed background prior to having contact with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	01440		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01440	Continued From page 35 individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of three unlicensed personnel ((ULP)-B and ULP-G). 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: On February 7, 2023, at approximately 8:30 a.m., ULP-B provided oral medications and cares to residents. ULP-B was hired on December 21, 2021. ULP-B's Resident Assistant Skills Checklist dated January 5, 2022, indicated ULP-B's employee record lacked evidence director of nursing (DON)-A conducted direct supervision of the employee performing a delegated task on	01440		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

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KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01440	Continued From page 36 medication/treatment within 30 days the employee had first performed the delegated task for residents. On February 7, 2023, at approximately 8:50 a.m., ULP-G provided oral medications to residents. ULP-G was hired on November 5, 2019. ULP-G's Resident Assistant Skills Checklist dated November 30, 2019, indicated ULP-G's employee record lacked evidence DON-A conducted direct supervision of the employee performing a delegated task on medication/treatment within 30 days the employee had first performed the delegated task for residents. On February 7, 2023, at 11:50 a.m. DON-A indicated ULP-B's and ULP-G's record lacked documentation of a 30-day supervision for the delegated tasks of medication administration. LALD-D indicated the licensee was aware of the lacking documentation but had yet to audit ULP-B's and ULP-G's record and complete the missing documentation. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated April 19, 2022, indicated staff who provided delegated tasks would have written records, signed by a RN regarding ULP competency testing of delegated medication administration or treatment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01620	Continued From page 37	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an ongoing resident reassessment that did not exceed 90 days as required for four of five residents (R3, R4, R5, R6). Additionally, the licensee failed to ensure the RN completed a comprehensive reassessment after a change of condition for one of one resident (R9) after 13 documented falls.	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01620	Continued From page 38 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: During the entrance conference on February 6, 2023, at approximately 10:20 a.m., director of nursing (DON)-A stated comprehensive assessments were completed upon admission, within 14 days, every 90 days and with changes in condition. 90-DAY ASSESSMENTS R3 R3 admitted to licensee for services on July 22, 2020. R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes, obesity, and reduced mobility. R3 received assistance with personal cares, medication and treatment management, mobility, homemaking, and laundry. R3's record indicated the RN completed a 90-day assessment on February 3, 2023 (162 days after the previous assessment on August 25, 2022). R4 R4 admitted to licensee for services on March 7, 2022. R4's medical record included diagnoses of type II	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01620	Continued From page 39	01620		

diabetes, multiple sclerosis (disease of the brain and spinal cord), legal blindness, and atrial fibrillation (abnormal heart rhythm). R4 received assistance with personal cares, medication and treatment management.

R4's record included a 14-day assessment dated March 29, 2022, a 90-day assessment dated August 15, 2022 (139 days after the previous assessment), and February 2, 2023 (171 days after the previous assessment).

R5
R5 admitted to licensee on June 8, 2019.

R5's medical record included diagnoses of cardiac murmur, hypertension (high blood pressure), localized edema (swelling), and type II diabetes. R5 received assistance with escorts to dining room, bath reminders, laundry, trash removal, and housekeeping.

R5's record included a 90-day assessment dated August 1, 2022, and on November 14, 2022 (13 days after the previous assessment).

R6
R6 admitted to licensee on April 29, 2020.

R6's medical record included diagnoses of Alzheimer's Disease, hypertension, and prediabetes. R6 received assistance with reminders to get dressed, minimal assist with bathing, bedmaking, and laundry.

R6's record included a 90-day assessment dated May 24, 2022, and one dated on November 4, 2022 (164 days after the previous assessment).

On February 7, 2023, at 3:48 p.m., DON-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01620	Continued From page 40 indicated many assessments probably weren't done since August 2022, due to Covid-19. DON-A indicated the assessments for everyone have been caught up now. CHANGE IN CONDITION R9 was admitted to licensee for services on August 5, 2021. R9's medical record included diagnoses of repeated falls, reduced mobility, unsteadiness on feet, and visual loss. R9 received assistance with medication administration, mobility, dressing, bathing, laundry, and housekeeping. R9 had 13 documented falls on the following dates: November 22, 2022; December 27, 2022 (hitting head); and January 6, 7, 13, 14 (hitting head), 18, 21, 22, 23,24, 28, 31, 2023. R9's record included a 90-day assessment dated August 24, 2022. R9's record also included a 90-day assessment dated February 2, 2023. R9's record lacked a change in condition assessment related to the 13 falls between assessments. R9's Observations note dated January 14, 2023, at 10:45 a.m., RN-H documented that R9 had "been markedly more confused in the last several weeks and medical provider is aware of that." On February 8, 2023, at 2:52 p.m., RN-H indicated she/he completes all the fall investigations where interventions would be put in place but did not complete a change in condition assessment to determine if needs were being met.	01620		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01620	Continued From page 41 The licensee's 6.01 Assessment, Reviews & Monitoring policy dated April 19, 2022, indicated ongoing resident reassessment and monitoring would be conducted as needed based on changes in the needs of the resident and could not exceed 90 calendar days from the last date of the assessment. The licensee's 6.19 Resident Change in Condition or Need policy dated April 19, 2023, indicated when changes in condition or needs are identified, a registered nurse will initiate a change in condition assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01700	Continued From page 42	01700		

needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

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 an individualized assessment with the required content for four of four residents (R3, R4, R5, R6).

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:

During the entrance conference on February 6, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-D and director of nursing (DON)-A stated the licensee provided medication management services to the licensee's residents who received services.

On February 7, 2023, between 8:15 a.m. and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01700	Continued From page 43 8:30 a.m., ULP-I administered medication to R3 and R4. R3 R3 admitted to licensee for services on July 22, 2020. R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes, obesity, and reduced mobility. R3 received assistance with personal cares, medication and treatment management, mobility, homemaking, and laundry. R4 R4 admitted to licensee for services on March 7, 2022. R4's medical record included diagnoses of type II diabetes, multiple sclerosis (disease of the brain and spinal cord), legal blindness, and atrial fibrillation (abnormal heart rhythm). R4 received assistance with personal cares, medication and treatment management. R5 R5 admitted to licensee on June 8, 2019. R5's medical record included diagnoses of dementia, hypertension, valve stenosis (narrowing), atrial fibrillation (abnormal heart rate), and type II diabetes. R5 received assistance with medication administration and minimal assistance with activities of daily living. R6 R6 admitted to licensee on April 29, 2020. R6's medical record included diagnoses of dementia, glaucoma, hypertension (high blood	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01700	Continued From page 44 pressure), and hypothyroidism (low thyroid). R6 received assistance with medication administration and minimal assistance with activities of daily living. R3, R4, R5, and R6's most recent 90-day assessments dated February 3, 2023, February 2, 2023, November 14, 2022, and November 4, 2022, respectfully, lacked the required information: -The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On February 8, 2023, at 10:40 a.m., director of nursing (DON)-A confirmed the assessments lacked the above required content. The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment dated April 19, 2022, indicated the assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

(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 45 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 develop an individualized medication management record with the required content for three of four residents (R3, R5, R6). 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: During the entrance conference on February 6, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-D and director of nursing (DON)-A stated the licensee provided medication management services to the licensee's residents who received services. On February 7, 2023, between 8:15 a.m. and 8:30 a.m., ULP-I administered medication to R3 and R4. R3 R3 admitted to licensee for services on July 22, 2020.	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

(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 46 R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes, obesity, and reduced mobility. R3 received assistance with personal cares, medication and treatment management, mobility, homemaking, and laundry. R3's record indicated the RN completed a 90-day assessment on February 3, 2023. R5 R5 admitted to licensee on June 8, 2019. R5's medical record included diagnoses of dementia, hypertension, valve stenosis (narrowing), atrial fibrillation (abnormal heart rate), and type II diabetes. R5 received assistance with medication administration and minimal assistance with activities of daily living. R5's record indicated the RN completed a 90-day assessment on November 14, 2022. R6 R6 admitted to licensee on April 29, 2020. R6's medical record included diagnoses of dementia, glaucoma, hypertension (high blood pressure), and hypothyroidism (low thyroid). R6 received assistance with medication administration and minimal assistance with activities of daily living. R6's record indicated the RN completed a 90-day assessment on November 4, 2022. R3, R5 and R6's record lacked monitoring and reassessment of medication management services at least annually for the following: - documentation the assessment was conducted	01710		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01710	Continued From page 47 face-to-face with the resident; - identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - identification of interventions needed in management of medications; and -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On February 8, 2023, at 10:40 a.m., director of nursing (DON)-A confirmed the assessments lacked the above required content at least annually. The licensee's 7.01 Medication Management-Assessment, Monitoring & Reassessment policy dated April 19, 2022, indicated the licensee would monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

(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
01730	Continued From page 48 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

(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
01730	Continued From page 49	01730		

individualized medication management record with the required content for four of four residents (R3, R4, R5, R6).

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:

During the entrance conference on February 6, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-D and director of nursing (DON)-A stated the licensee provided medication management services to the licensee's residents who received services.

On February 7, 2023, between 8:15 a.m. and 8:30 a.m., ULP-I administered medication to R3 and R4.

R3
R3 admitted to licensee for services on July 22, 2020.

R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes, obesity, and reduced mobility. R3 received assistance with personal cares, medication and treatment management, mobility, homemaking, and laundry.

R4
R4 admitted to licensee for services on March 7,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

(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
01730	Continued From page 50 2022. R4's medical record included diagnoses of type II diabetes, multiple sclerosis (disease of the brain and spinal cord), legal blindness, and atrial fibrillation (abnormal heart rhythm). R4 received assistance with personal cares, medication and treatment management. R5 R5 admitted to licensee on June 8, 2019. R5's medical record included diagnoses of dementia, hypertension, valve stenosis (narrowing), atrial fibrillation (abnormal heart rate), and type II diabetes. R5 received assistance with medication administration and minimal assistance with activities of daily living. R6 R6 admitted to licensee on April 29, 2020. R6's medical record included diagnoses of dementia, glaucoma, hypertension (high blood pressure), and hypothyroidism (low thyroid). R6 received assistance with medication administration and minimal assistance with activities of daily living. R3, R4, R5, and R6's most recent medication management plan dated February 3, 2023, February 2, 2023, November 14, 2022, and November 4, 2022, respectfully, lacked the required information: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis On February 8, 2023, at 10:40 a.m., director of nursing (DON)-A confirmed the assessments	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01730	Continued From page 51 lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01790	Continued From page 52 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) who provided medications to residents for unplanned time away from home when the licensed nurse was not available for one of one unlicensed personnel (ULP-B).	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

(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
01790	Continued From page 53 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-B was hired on December 21, 2021. ULP-B's record lacked documentation of training and competency for unplanned time away related to medication administration when the RN is not available. On February 6, 2023, at approximately 1:45 p.m., director of nursing (DON)-A indicated ULP-B's lacked training, documentation of training, and competency for unplanned times away. DON-A stated ULPs contact the RN for direction when residents had unplanned time away. DON-A stated documentation of competency for residents unplanned time away would not be in any employee records. The licensee's 7.10 Medication Management - Planned & Unplanned Time Away policy dated April 19, 2022, indicated the required training and competency for ULPs related to unplanned time away would be provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01830	Continued From page 54	01830		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for three of five residents (R3, R5, R6). 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: R3 R3 admitted to the licensee for services on July 22, 2020. R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes, obesity, and reduced mobility. R3's 90 Day Assessment (which is also the licensee's service agreement) dated February 3, 2023, indicated R3 received assistance with personal cares, medication and treatment management, mobility, homemaking, and	01830		

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01830	Continued From page 55 laundry. R3's medical record lacked annual signed provider orders. R5 R5 admitted to licensee for services on June 8, 2019. R5's medical record included diagnoses of dementia, hypertension (high blood pressure), valve stenosis (narrowing), atrial fibrillation (abnormal heart rhythm), and diabetes type II. R5's 90 Day Assessment (which is also the licensee's service agreement) signed by the registered nurse on November 14, 2022, and by R5's responsible party on December 7, 2022, indicated R5 received medication administration and minimal assistance with activities of daily living. R5's medical record lacked annual signed provider orders. R6 R6 admitted to the licensee for services on April 29, 2020. R6's medical record included diagnoses of dementia, glaucoma, hypertension, and hypothyroidism (low thyroid). R6's 90 Day Assessment (which is also the licensee's service agreement) signed on May 25, 2022, indicated R6 received medication administration and minimal assistance with activities of daily living. R6's medical record lacked annual signed	01830		

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01830	Continued From page 56 provider orders. On February 9, 2023, at approximately 2:30 p.m., director of nursing (DON)-A indicated they were not aware annual prescription orders were required. DON-A stated going forward, they will have medical providers sign orders for every resident receiving medication management. The licensee's 7.18 Medication & Treatment Orders - Renewal policy dated April 19, 2022, indicated medication and treatment orders must be renewed every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an opened insulin pen was correctly dated when the insulin would expire for one of one resident (R3). Additionally, the licensee failed to monitor for expired medication for one of two unidentified residents.	01890		

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01890	Continued From page 57 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: INSULIN LABEL On February 7, 2023, at approximately 8:20 a.m., the surveyor observed R3's Lantus insulin pen with an open date of "2/4," but expiration date was labeled as "11/30/24." The Lantus insulin pen did not have a pharmacy label to identify whose insulin this belonged to. The surveyor then observed a Novolog insulin pen with open date of "1/24/23," and expiration date of "8/31/24." R3 admitted to the licensee for services on July 22, 2020. R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes, obesity, and reduced mobility. R3's 90-Day Assessment (which is also the licensee's service agreement) dated February 3, 2023, indicated R3 received assistance with personal cares, medication and treatment management, mobility, homemaking, and laundry. R3's Medication Administration Record (MAR) dated February 2023 read, "Lantus 30 units, give Lantus insulin 30 units subcutaneous every	01890		

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01890	Continued From page 58	01890		

morning for diabetes management." Additionally, the MAR read, "Novolog 6 units, give 6 units Novolog insulin 15 minutes before lunch and supper for diabetes. Hold if blood sugar less than 130."

On February 7, 2023, at approximately 8:25 a.m., registered nurse (RN)-H indicated R3's insulin pen should have had a pharmacy label to identify whose Lantus insulin pen it belonged to and indicated the staff did not label the expiration date properly. RN-H indicated they had recently trained staff on proper labeling of insulin pens. Unlicensed personnel (ULP)-I proceeded to administer the scheduled unlabeled Lantus insulin dose to R3.

On February 8, 2023, at 11:20 a.m., ULP-L indicated he/she was putting the manufacturer's expiration date and wasn't aware of insulin expiring 28 days of being opened.

EXPIRED MEDICATION
On February 8, 2023, at 11:20 a.m., the surveyor and RN-H located a plastic clear bag labeled "#13." The plastic bag contained a bottle of nasal spray that did not contain any resident information. The manufacturer's expiration date was January 2019. RN-H did not know who this medication belonged to as room #13 had two occupants. RN-H removed the nasal spray from the medication cart to discard.

Manufacturer's instructions for Lantus FlexPen date June 2022, indicated the opened pen should be stored at room temperature (up to 86 degrees Fahrenheit) for up to 28 days.

Manufacturer's instructions for Novolog FlexPen date February 2023, indicated the opened pen

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01890	Continued From page 59 should be stored at room temperature (up to 86 degrees Fahrenheit) for up to 28 days. The licensee's 7.36 Insulin policy dated April 19, 2022, indicated if the licensee could not read the label, or if the MAR and the label do not all say the same thing, stop and call the nurse for instructions. The licensee's 7.13 Medications-Prescription Drugs & Prohibition policy dated April 19, 2022, indicated any prescription drug dispensed by the pharmacy must bear the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. The licensee's 7.23 Medication Disposal policy dated April 19, 2022, indicated the licensee would dispose of any medications remaining with the facility that are discontinued or expired. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01920 SS=E	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include	01920		

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01920	Continued From page 60 verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to follow procedure for loss and spillage of a controlled substance that was managed by the licensee for two of two residents (R7, R10). 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: On February 8, 2023, at 11:37 a.m., during medication cart review, surveyor observed two narcotic cards belonging to R7 and R10, which had sealed white pill envelopes stapled to the bubble pack with unknown contents inside. R7 R7 was admitted to licensee for services on May 24, 2016.	01920		

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01920	Continued From page 61 R7's 90-Day Assessment signed by a registered nurse on August 15, 2022, and by R7's responsible party on August 25, 2022, indicated R7 received medication management services. R7's Medication Administration Record (MAR) dated February 2023, indicated R7 received oxycodone 5 milligram (mg)-give ½ tab (2.5 mg) by mouth every six hours as needed for moderate to severe pain. R7's oxycodone 5 mg tablet bubble pack card indicated each bubble contained one half tablet (used for pain) where bubble #2 was empty (broken foil). The stapled pill envelope attached to the bubble pack had the following information: -No. 11 Mr. -Date: 9/21 -Directions: Oxy 5 mg, fell out of card R10 R10 admitted to licensee for services on December 3, 2018. R10's 90-Day Assessment signed February 9, 2022, indicated R10 received medication management services. R10's medical record indicated R10 received Ativan (lorazepam) 0.5 mg tablet twice a day as needed (PRN) for agitation. R10's lorazepam 0.5 mg tablet bubble pack card indicated each bubble contained a whole tab (used for anxiety) where bubble #30 was punched out on March 14 with staff initials. The stapled pill envelope attached to the bubble pack had the following information: -No. 11	01920		

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01920	Continued From page 62 -Date: 3/14 -Directions: Ativan .5 mg On February 8, 2023, at 11:37 a.m., registered nurse (RN)-H did not know the medications in the envelope needed to be wasted per the licensee's policy. RN-H indicated no investigation or incident reports were completed. Unlicensed personnel (ULP)-L and surveyor observed the narcotic ledger where R7 and R10's medications are documented, and the ledger lacked any documentation the medications were either removed or transferred. The licensee's 7.07 Medication Loss or Spillage policy dated April 19, 2022, indicated when loss or spillage of medications, including schedule II medications occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the loss or spillage and include verification that any contaminated substance was disposed of according to state and federal regulations. Additionally, a medication error report form must be completed, and that staff would notify a nurse where the nurse would investigate the situation and document it in the resident's record. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01920		
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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 63 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescribed orders for a treatment and therapy for one of four residents (R3). 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	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01940	Continued From page 64 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: R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes, obesity, and reduced mobility. On February 7, 2023, at 9:00 a.m., unlicensed personnel (ULP)-I checked R3's blood glucose prior to insulin administration. R3's admission orders signed on July 16, 2020, instructed to check R3's blood glucose twice a day in the morning and in the evening. R3's February 2023 Medication Administration Record (MAR) indicated to check R3's blood glucose three times a day before breakfast, lunch, and dinner. R3's record lacked physician orders to check blood glucose three times a day. During an interview on February 8, 2023, at 12:24 p.m., registered nurse (RN)-H was unable to locate the current orders for blood glucose checks. RN-H indicated they would keep looking for it. On February 9, 2023, at 1:20 p.m., director of nursing (DON)-A indicated they could not locate the current blood glucose order and when they contacted R3's medical provider to obtain the order, the medical provider did not have the order on file either. The medical provider created a new blood glucose order to add to R3's medical	01940		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01940	Continued From page 65 record. The licensee's 7.20 Medications and Treatment Orders policy dated April 19, 2022, indicated the RN is responsible for assuring the current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescribed orders for a treatment and therapy for one of four residents (R3). 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	01970		

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01970	Continued From page 66 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: R3's medical record included diagnoses of narcolepsy (sleep disorder), type II diabetes, obesity, and reduced mobility. On February 7, 2023, at 9:00 a.m., unlicensed personnel (ULP)-I checked R3's blood glucose prior to insulin administration. R3's admission orders signed on July 16, 2020, instructed licensee to check R3's blood glucose twice a day in the morning and in the evening. R3's February Medication Administration Record indicated licensee to check R3's blood glucose three times a day before breakfast, lunch, and dinner. R3's record lacked physician orders to check blood glucose three times a day. During an interview on February 8, 2023, at 12:24 p.m., registered nurse (RN)-H was unable to locate the current orders for blood glucose checks. RN-H indicated they would keep looking for it. On February 9, 2023, at 1:20 p.m., director of nursing (DON)-A indicated they could not locate the current blood glucose order and when they contacted R3's medical provider to obtain the order, the medical provider did not have the order on file either. The medical provider created a new blood glucose order to add to R3's medical record.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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01970	Continued From page 67 The licensee's 7.20 Medications and Treatment Orders policy dated April 19, 2022, indicated the RN is responsible for assuring the current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide hazard vulnerability assessment (or safety risk assessment) plan to identify hazard vulnerabilities and mitigations of the physical environment on and around the property for the facility to protect the memory care residents from harm. This deficient practice had the ability to affect all staff, residents, and visitors.	02040		

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	32045	A. BUILDING: _____ B. WING _____	02/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE PLACE AT LAVALLE FIEL	14602 FINALE AVE N HUGO, MN 55038

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02040	Continued From page 68 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: Document review and inteview was conducted on February 8, 2023, at approximately 4:30 p.m., with the Licensed Assisted Living Director (LALD)-D and the Facilities Director (FD)-K, on the safety risk assessment plan for the physical environment of the facility to protect the memory care residents from harm. Document review indicated that the licensee had performed an all-in-one baseline hazard vulnerability assessment for the facility provided by an insurance company, AFM Risk report, dated March 3, 2022, but failed to include specific vulnerability factors affecting the memory care aspects of the facility and mitigation strategies to protect the memory care residents from harm. The LALD-D agreed that their assessment lacked these provisions. On February 8, 2023, at approximately 5:30 p.m., during the interview, survey staff discussed the findings and explained to the LALD-D that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, and mitigated and be documented in the plan documentation to protect the memory care residents from harm. LALD-D acknowledged the	02040		

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02040	Continued From page 69 findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to	02110		

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02110	Continued From page 70 and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures for four of four residents (R3, R4, R5, R6). 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: R3 was admitted on July 22, 2020. R4 was admitted on March 7, 2022. R5 was admitted on June 8, 2019. R6 was admitted on April 29, 2020. R3, R4, R5, and R6's records lacked documentation they or their designated representatives received the required policies and procedures (P/P) to be provided. On February 7, 2023, at 4:05 p.m., licensed	02110		

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02110	Continued From page 71 assisted living director (LALD)-D indicated the licensee was aware the identified policies and procedures were required to be provided to the residents at the time of move in. LALD-D stated although the licensee had developed the required P/P, the licensee failed to provide the P/P to any resident who resided in the facility. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies dated April 19, 2022, indicated policies must be provided to residents and the resident's legal and designated representatives at time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and	02170		

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02170	Continued From page 72 non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activity plan contained all required content for four of four residents (R3, R4, R5, R6). 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: R3 was admitted on July 22, 2020. R4 was admitted on March 7, 2022.	02170		

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02170	Continued From page 73 R5 was admitted on June 8, 2019. R6 was admitted on April 29, 2020. R3, R4, R5, and R6's records lacked an activities evaluation to address the residents' past interests, current abilities and skills, emotional and social needs and patterns, physical limitations, and identifications of activities for behavioral interventions. On February 8, 2023, at approximately 10:40 a.m., director of nursing (DON)-A stated R3, R4, R5, and R6's activities evaluation had not been completed, and DON-A also indicated licensee failed to complete the activities evaluation for any resident residing in the facility. The licensee's 3.05 ALDC Life Enrichment Programs, Activities & Outdoor Space policy dated April 19, 2022, indicated an activities assessment would be completed for each resident, and identification of the required content for the evaluation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=I	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 standards.	02310		

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02310	Continued From page 74 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for two of two residents (R3, R7) who utilized side rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R3 On February 7, 2023, at approximately 9:00 a.m., during care observation, the surveyor observed raised bilateral (two) side rails on R3's occupied hospital bed. R3 was admitted to the licensee on July 22, 2020. R3's 90 Day Assessment, which director of nursing (DON)-A indicated is the service agreement, dated February 3, 2023, indicated R3 received services including medication management, bathing, grooming, dressing, transfers, and mobility. R3's assessment did not include side rail assessment. R3's medical record lacked documentation of the following: - a completed side rail assessment;	02310		

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02310	Continued From page 75 - the risks and benefits were discussed with the resident/responsible party; - zone measurements per the Food and Drug Administration (FDA) guidelines for zones of entrapment; and - the side rail was FDA compliant. On February 7, 2023, at approximately 9:00 a.m., unlicensed personnel (ULP)-I indicated R3 had the hospital bed with side rails for a few months. R7 On February 7, 2023, at approximately 9:30 a.m., the surveyor observed a single side rail on right side of R7's bed. The side rail was a single loop shaped like an oval and attached to the bed frame. R7 was admitted to the licensee on May 24, 2016. R7's medical record lacked documentation of the following: - a completed side rail assessment; - the risks and benefits were discussed with the resident/responsible party; - the portable side rail has not been recalled by the Consumer Product Safety Commission (CPSC); - the portable side rail was installed and maintained per manufacturer's guidelines; and - the manufacturer's guidelines were accessible upon request. On February 7, 2023, at 11:03 a.m., DON-A indicated he/she was not aware R3 had a hospital bed or side rails until today. DON-A acknowledged a risk and benefit discussion was not completed for any resident with hospital side rails or consumer side rails. DON-A was not	02310		

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02310	Continued From page 76	02310		

aware to check for consumer side rail recalls on the CPSC website. DON-A indicated he/she not measure any hospital side rails for compliance with the FDA. The surveyor showed DON-A the licensee's Side Rails policy and explained the policy included the missing requirements. DON-A indicated the licensee begun completing the missing information listed above.

The licensee's 6.28 Side Rails policy dated April 19, 2022, indicated when the licensee is aware a resident is utilizing side rails on a bed, the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use of a safe design and utilized consistent with the manufacturer's directions. This policy should be followed regardless of who owns or is supplying the side rail. Additionally, the licensee would determine if the side rail was considered to be safe and the side rail was used consistent with manufacturer's directions.

The FDA's A Guide to Bed Safety, dated March 10, 2006, indicated licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions.

No further information was provided.

TIME PERIOD FOR CORRECTION: Immediate

On February 9, 2023, the immediacy of correction order 2310 has been removed as confirmed by evaluator onsite review, however non-compliance remains at a scope and level of I.

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DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *02/06/23*
Time: 11:00:00
Report: 1031231017

Food and Beverage Establishment Inspection Report

Location:
Keystone Place At Lavalle Fiel
14602 Finale Ave N
Hugo, MN55038
Washington County, 82

Establishment Info:
ID #: 0039309
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6518886557
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.

No NEW orders were issued during this inspection.

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

Visit was conducted as part of a HRD survey. The food service is being conducted by a contracted company, New Horizon Foods. Per the current HRD policy, this facility will be issued a license from the local licensing authority (Washington County).

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

I acknowledge receipt of the Environmental Health inspection report number 1031231017 of 02/06/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and mailed.

Signed:_____
Establishment Representative

Signed:_____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us