Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294562942M
Compliance #: HL294561536C

Date Concluded: July 6, 2026

Name, Address, and County of Licensee Investigated:
Keystone Bluffs Assisted Living
2528 Trinity Road 713
Duluth, MN 55811
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
Two residents (Resident #1, and Resident #2) were neglected when the facility failed to provide necessary care, services, and interventions, to help prevent new and worsening pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for neglect. Resident #1 was neglected when the facility failed to implement orders for pressure ulcer wound care, and pain management. Resident #1 was transferred to the Emergency Department (ED) with uncontrolled pain and admitted to the hospital. After Resident #1 was re-admitted to the facility they failed to ensure care and services were provided causing the pressure ulcer to worsen. Resident #2 who had an indwelling urinary catheter to help promote pressure ulcer healing, was neglected when the facility failed to provide catheter care as scheduled based on a standard of practice and failed to implement/ provide wound care and repositioning as ordered. Resident #2 required hospitalization for treatment of pressure ulcer and urinary tract infections.

A concern arose when it was reported the facility failed to ensure care, services, and providers orders were implemented/followed causing worsening pressure ulcers and increased pain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family members, medical, and hospice providers. The investigation included review of the resident record(s), death record, hospital records, facility incident reports, personnel files, and related facility policy and procedures. Also, the investigator observed residents and staff in the facility.

The facility Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated they provided wound care basic and complex in collaboration with hospice and/or homecare. The UDALSA indicated the facility provided end of life care, incontinence care, chair/bed mobility, indwelling urinary catheter care, and emptied urinary catheter drainage bags.

Resident #1

Resident # 1 resided in an assisted living facility with diagnoses including polyneuropathy (damage of nerves which can cause numbness, tingling, or burning pain), moderate dementia with other behavioral disturbance, pain in left and right shoulders, stroke with right sided weakness, and generalized muscle weakness.

Resident #1's admission assessment indicated the resident required assistance with dressing, transfers, toileting, and personal hygiene. The skin assessment indicated Resident #1 had no pressure ulcers on admission.

Two days after admission to the facility, a provider After Visit Summary (AVS) indicated Resident #1 was seen at the facility to establish care with no wounds present at that time.

11 days later, a provider AVS follow up indicated Resident #1 had a "NEWLEY acquired sacral wound caused by pressure." The AVS indicated Resident #1 described his pain as "unbearable", and that it was "torture to live this way", and staff "forgot about him all the time." The AVS included orders to clean the wound with wound cleanser, pat dry, apply skin prep to peri wound area, and cover with boarder foam dressing 3 times weekly, and as needed (PRN) for soiling/saturation/or falling off. The orders included Dilaudid (a narcotic pain medication) 1 milligram (mg) twice daily (BID) and BID/PRN, and Duloxetine (medication used to treat pain, anxiety, and depression) 20 mg daily. The AVS included orders for a referral to home healthcare nursing to evaluate, manage, and treat the pressure ulcer. However, Resident #1's record indicated these orders for wound care, referral for wound management, and pain management/medication were never implemented.

The day after Resident #1 was seen by his provider, the facility completed a 14-day post admission assessment, with no changes noted. The facility assessment failed to identify Resident #1 had developed a pressure ulcer or had new orders for wound care and medication to help manage his pain.

Three days after the 14-day assessment, a facility progress note indicated Resident #1 reported uncontrolled pain stating he “wanted to end it all and die.” The note indicated Resident #1 was transferred to the emergency department and was subsequently admitted to the hospital.

A hospital AVS indicated Resident #1 was hospitalized for confusion and intractable pain, then discharged back to the facility 6 days later. The AVS discharge instructions included orders for wound care which instructed to clean the wound with saline and gauze, then apply a Mepilex border dressing every 3 days, however those orders were not implemented until 4 days later, then were not completed as scheduled/ordered.

The day after Resident #1 was readmitted to the facility from the hospital. A facility assessment indicated Resident #1 was admitted to hospice for end-of-life care. The assessment indicated Resident #1 was dependent on staff for dressing, required two staff and a mechanical standing lift for transfers, and was incontinent. The assessment indicated Resident #1 had a Stage II pressure ulcer partial thickness on his coccyx. The assessment lacked interventions including wound care, monitoring, scheduled incontinence management, or repositioning to help prevent new or worsening pressure ulcers.

Two days later a progress note indicated concerns with facility failure to provide toileting and incontinence cares was reported after Resident #1 was found soaked with urinary incontinence during a hospice visit. The note indicated every 2-hour incontinence care and repositioning were then scheduled.

A change of condition assessment completed (7 days after readmission) indicated Resident #1 had a Stage II pressure injury wound on his coccyx measuring 3.0 centimeters (cm) by 2.0 cm by 1.5 cm deep with tunneling present. The assessment indicated Resident #1 should be repositioned every two hours.

A complaint form indicated the facility was made aware of concerns repositioning was not being provided. The complaint form indicated family was educated that Resident #1 wanted to sleep in his recliner, not in his bed, and micro shifting was provided while Resident #1 was in his recliner. However, the record failed to indicate repositioning was consistently provided.

Around the same time progress notes indicated hospice also reported concerns Resident #1 was not being repositioned and not sleeping in his bed. The notes indicated Resident #1 refused services and refusal of care was being added to documentation. However, Resident #1’s record lacked documentation to show refusal or non-compliance with services offered.

A new providers orders for wound care included direction to cleanse the area with soap and water, pat dry and apply a zinc based moisturized BID and PRN. The orders indicated that the facility should assist Resident #1 to reposition often.

The next day a facility progress note indicated Resident #1 had increased staging on his coccyx pressure ulcer and the nurse would check Resident #1's services daily to ensure they were being provided. The note indicated Resident #1 routinely refused services, but the record lacked documentation to show Resident #1 had routinely refused or why the services were not offered/provided. The record lacked documentation the facility provided daily supervision of tasks delegated to ensure they were provided/completed as indicated in the progress note.

Less than a week later Resident #1's provider ordered wound care daily and PRN. According to the resident's record daily wound care was not completed or provided.

The same day a facility progress note indicated Resident #1 had developed tunneling in his sacral wound and a new secondary pressure ulcer had developed. The record indicated daily wound care was scheduled but never provided.

3 days later Resident #1's record indicated the resident was transferred to another facility for a higher level of care.

Resident #1's Medication Administration Record (MAR) indicated orders for Dilaudid were not implemented when ordered prior to Resident #1 being hospitalized with uncontrolled pain and were not on Resident #1's MAR for staff to administer until after readmission from the hospital and subsequent hospice admission, and the Duloxetine order was never implemented.

Resident #1's Treatment Administration Record (TAR) indicated orders for wound care were not implemented or provided prior to Resident #1 being hospitalized and had no wound care until 4 days after re-admission from the hospital with hospice. Although Resident #1's TAR included wound care scheduled every 3 days. The service was often blank, not provided 15 of the 18 times scheduled with no refusal of care/services documented on those days.

<u>Resident #1's Service Delivery Record included:</u>
Toileting assistance service scheduled AM, PM, and during the night shift. The toileting service record was blank, not provided 96 times scheduled over approximately 2 months, with no refusal of care at those times.

Medical monitoring skin condition service indicated that weekly skin monitoring should be completed, and any skin concerns should be communicated to the resident's provider. The service was never completed or provided since admission with no refusal of care.

Incontinence care service scheduled every 2 hours (12 times daily) was blank, not provided 400 times scheduled over approximately 2 months, with no refusal of care at those times.

Repositioning service initiated scheduled every 2 hours (12 times daily) was blank, not provided 409 scheduled over approximately 2 months, with no refusal of care at those times. Resident #1's service record for repositioning after concerns were reported to the facility showed the

resident continued to have extended periods of time from 10-24 hours where no repositioning was offered/provided increasing Resident #1's risk for new or worsening pressure ulcers.

Although Resident #1's record had occasional refusal of services, the service record was frequently blank indicating the services were not provided or offered to Resident #1 rather than that the resident frequently refused. After the facility was made aware of concerns with the provision of care and after Resident #1's pressure ulcer worsened, Resident #1's record lacked documentation to show supervision of delegated tasks for toileting, incontinence care, repositioning, and dressing changes were provided to ensure the services were completed.

When interviewed leadership stated they were aware of issues with care/services, assessments, monitoring, and supervision of delegated service tasks for Resident #1. Leadership indicated nurses were under the impression someone else was doing Resident #1's wound care, assessments, and monitoring. Leadership stated they expected providers orders to be implemented timely and indicated nurses should review each AVS to ensure orders were not missed. Leadership indicated they made changes to improve the provision of care for residents.

When interviewed several unlicensed staff stated Resident #1 was cooperative and compliant with care and services when offered and rarely refused. Staff stated they frequently found Resident #1 saturated head to toe with urinary incontinence or with dried stuck on fecal matter like no one had helped him for a long time. Staff stated Resident #1 frequently appeared uncared for in the same dirty clothing for days. Staff stated every two-hour incontinence care and repositioning were not provided for Resident #1.

When interviewed hospice staff stated Resident #1's pressure ulcer worsened quickly due to the lack of incontinence care, repositioning, and wound care from the facility causing increased pain and suffering at the end of life. Hospice staff indicated they reported concerns that care and services were not being provided to leadership who expressed concern, but nothing changed.

When interviewed Resident #1's family stated they had concerns Resident #1 was not getting toileting, incontinence care, or repositioning and reported their concern to leadership but nothing changed so Resident #1 was moved to another facility to get the care he needed.

Resident #2

Resident #2 resided in an assisted living facility with diagnoses including sacral wound (prior to admission to the facility), deep vein thrombosis, stroke with left side hemiparesis (partial weakness or inability to move one side of the body), shoulder impingement, and diabetic neuropathy. Resident #2's quarterly assessment indicated she required one staff assistance with transfers and toileting as requested. The assessment identified Resident #2 had an indwelling urinary catheter but failed to include interventions as a standard of care for the catheter including providing periurethral cleaning and drainage bag emptying to help prevent urinary tract infections. The assessment skin section indicated Resident #2 had moisture pressure on

their coccyx but failed to indicate Resident #2 had a pressure ulcer, and lacked wound care, wound monitoring, or interventions to help prevent new or worsening pressure ulcers.

A facility provided AVS indicated Resident #2 was seen at the facility by her provider after a catheter lumen was found digging into her buttocks wound. The AVS indicated Resident #2 had several issues with her urinary catheter being improperly attached to her wheelchair resulting in the bag dragging on the ground and being pulled, and several episodes of blood in her urine likely related to improper catheter management.

The following day a facility wound assessment form indicated Resident #2 had excoriation on her buttocks that was boggy, macerated, and red with bloody drainage measuring 4.0 cm by 1.5 cm. The assessment failed to identify Resident #2 had a pressure ulcer and lacked any wound treatment plan or interventions. The wound assessment included a note indicating Resident #2 had a large amount of blood dripping from the wound and a blood clot had dislodged when the brief was removed. The note indicated the wound was cleansed, Medi honey was applied, and then was covered with a Mepilex dressing. The note indicated that a lumen from her catheter caused the injury when it was pulled into her brief.

A wound assessment form (10 days later) contained the exact information with a note detailing the catheter lumen injury and wound care provided previously. As a result, there was no indication wound assessment, or wound care was provided on this day.

10 days later a facility provided wound clinic AVS indicated Resident #2 had two stage III pressure ulcers on her gluteal area. The AVS indicated the left gluteus pressure ulcer measured 10.7 cm by 4.5 cm by 0.1 cm deep, and the right gluteus pressure ulcer measured 0.7 cm by 0.7 cm by 0.1 cm deep. The AVS included orders for daily wound care which instructed to wash the wounds with a solution of 1 tablespoon of white vinegar in 1 cup of water, pat dry, apply Mupirocin antibiotic ointment to the wound beds, then apply Triad barrier cream to the peri wound areas and cover with 7X7 Allevyn Life Sacral Dressing over the wounds. The AVS had ordered interventions including repositioning every 2 hours to help heal and prevent new or worsening pressure ulcers.

A wound assessment form (completed 34 days after the last wound assessment) indicated Resident #2 had a stage II pressure injury, the assessment did not align with the wound clinic providers assessment and staging of the wound. The assessment lacked accurate current wound care and interventions as ordered from the wound clinic.

A facility provided wound clinic AVS one week later indicated Resident #2 was again seen for wound care management with a continuation of orders from the week prior. However, the record failed to indicate the facility implemented the orders.

Resident #2’s plan of care updated after the investigator was onsite lacked interventions to care for Resident #2’s indwelling urinary catheter to help prevent catheter associated urinary tract

infections including cleansing perineal care and draining the urinary collection bag. The plan of care identified Resident #2 had limited bed mobility due to the presence of pressure ulcers. The plan of care lacked interventions for assistance with mobility as assessed or repositioning as ordered to help prevent new or worsening pressure ulcers. The care plan included a wound treatment plan which was not accurate or according to the wound clinics AVS orders provided.

Resident #2's Service Delivery Record included:
Wound Care Simple service included instructions for staff to cleanse Resident #2's abdominal folds but lacked directions for Resident #2's pressure ulcer wound care as ordered.

Special Skin Care service included instructions to apply Triad to the resident's buttocks, coccyx, and inner thigh scheduled morning and evening. The service was blank, not provided 39 times scheduled over approximately one month, with no refusal of care documented on those days. The instructions lacked direction for pressure ulcer wound care as ordered.

Empty Catheter service included instructions to empty Resident #2 drainage bag scheduled 3 times daily each shift. The service was blank 41 times scheduled, over approximately one month, with no refusal of care on those days. In addition, Resident #2's progress notes included instances of Resident #1's catheter drainage bag not being emptied and was to the point of almost bursting past 2000 milliliters (ml) because the previous shifts had not emptied it.

Supervision with catheter care service was scheduled weekly but was blank, indicating the service was never completed/provided with no refusal.

Supervision with wound care service scheduled every morning was blank, indicating the service was never completed/provided with no refusal.

Mobility assistance with transfers service was not implemented as assessed one month prior. In addition, the record indicated no repositioning was implemented or provided as ordered.

Resident #2's services failed to include daily pressure ulcer wound care as ordered. Although Resident #2's progress notes indicated some wound care was provided (3 times in one month), the wound care was not completed daily or according to the wound clinic providers orders.

Supervision wound care service was scheduled every evening daily but was blank indicating the service was never completed/provided with no refusal.

About one month later a hospital AVS indicated Resident #2 was admitted to the hospital for altered mental state and wound check. The resident was diagnosed with sepsis and treated with intravenous antibiotics for pressure ulcer wound infection and urinary tract infection. When interviewed a wound care clinic provider stated they had been treating Resident #2's pressure ulcer wounds weekly for the last 5 weeks, and the orders from the AVS provided by

the facility were not new and had been in place since the start of care. The wound clinic indicated Medi honey and Mepilex had not been part of their orders since the start of care.

During email and interview facility leadership indicated the facility was responsible to provide wound care as ordered. Facility leadership indicated they thought the most recent wound care clinic orders were new and had not implemented them prior to Resident #2 being hospitalized. Leadership indicated the nurse had provided wound care according to orders at that time which included Medi honey and Mepilex, and indicated they were not aware the wound care clinic orders had not been implemented for Resident #2's pressure ulcer wounds since the start of care over the last 5 weeks. Leadership indicated nursing staff should review each AVS to ensure all orders were implemented. Leadership indicated catheter care including periurethral cleansing had never been implemented/provided as expected based on as a standard of care to help prevent infections.

When interviewed, unlicensed staff indicated they thought Resident #2 was independent with transfers and mobility and had not provided assistance to Resident #2. Staff denied ever providing catheter cares including periurethral cleansing to prevent infections and described recurring issues with the resident's urinary catheter drainage bag not being emptied as scheduled and being overflowing to the point of bursting because staff were not emptying it.

When interviewed Resident #2's provider indicated they expected the facility to provide catheter care including cleansing around the urinary meatus catheter tubing insertion site and emptying the urine collection bag regularly to help reduce the risk of infections.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: N/A
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility indicated they were auditing resident records, providing staff education, and making changes to ensure resident needs were met.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
St. Lois County Attorney
Duluth City Attorney
Duluth Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL294562942M/#HL294561536C On May 27, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 91 residents receiving services under the provider's Comprehensive Assisted Living license. The following correction orders are issued for #HL294562942M/#HL294561536C, tag identification 1620, 1650, 2310, and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 1 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 2 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure accurate assessment and ongoing wound assessment/monitoring was completed as needed based on changes in the resident's needs for two of two resident's (R1 and R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and 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). Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) defined a Stage II pressure ulcer as a superficial partial thickness skin loss involving the dermis and/or epidermis. The ulcer presents as a abrasion, blister, or shallow shiny or dry crater with red/pink wound bed without slough. This stage should NOT be used to describe skin tears, tape burns, perineal dermatitis, maceration, or	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 3 excoriation. Stage III full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia. The ulcer presents as a deep crater with or without undermining adjacent tissue. Subcutaneous fat loss may be visible, but bone tendon and muscle are not exposed, visible, or palpable. Slough may be present but does not obscure the depth. May include undermining and tunneling. R1 R1 was admitted to the licensee on January 26, 2026, with diagnoses including polyneuropathy (damage of nerves which can cause numbness, tingling, or burning pain), moderate dementia with other behavioral disturbance, pain in left and right shoulders, stroke with right sided weakness, and generalized muscle weakness. On January 27, 2026, R1's admission assessment indicated he required assistance with dressing, transfers, toileting, and personal hygiene. R1's admission skin assessment indicated he had no pressure ulcers present on admission. On January 29, 2026, two days after R1's admission to the licensee, a provider After Visit Summary (AVS) indicated R1 was seen at the facility to establish care and indicated R1 had no wounds present at that time. On February 9, 2026, 11 days later, a provider AVS indicated R1 was seen for a follow and identified R1 had a "NEWLY acquired sacral wound caused by pressure." The AVS indicated R1 described his pain as "unbearable", and that it was "torture to live this way", R1 reported to the provider that staff "forgot about him all the time."	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 4 The AVS included orders to clean the wound with wound cleanser, pat dry, apply skin prep to peri wound area, and cover with boarder foam dressing 3 times weekly, and PRN for soiling/saturation/or falling off. The orders included Dilaudid (a narcotic pain medication) 1 milligram (mg) twice daily (BID), and BID as needed (PRN)., and Duloxetine (medication used to treat pain, anxiety, and depression) 20 mg daily. With a referral to home healthcare nursing to evaluate, manage, and treat R1's pressure ulcer. However, R1's record indicated these orders for wound care, referral for wound management, and pain management/medication orders were never implemented. On February 10, 2026, the day after R1 was seen by his provider, the licensee completed a 14-day post admission assessment, with no changes noted. The assessment failed to identify that R1 had developed a pressure ulcer or had new orders for wound care or pain medication to help manage his pain. On February 13, 2026, a facility progress note indicated R1 reported uncontrolled pain stating he "wanted to end it all and die." The note indicated R1 was transferred to the emergency department (ED) and was subsequently admitted to the hospital. On February 20, 2026, the day after R1 was readmitted to the licensee from the hospital. An assessment indicated R1 was admitted to hospice for end-of-life care. The assessment indicated R1 was dependent on staff for dressing, required two staff and a mechanical standing lift for transfers, and was incontinent of bowel and bladder. The assessment indicated R1 had a Stage II pressure ulcer partial thickness on his	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 5 coccyx. The assessment lacked measurements or description of the wound and had no interventions including wound care/monitoring, incontinence management, or repositioning/offloading to help prevent new or worsening pressure ulcers. On February 26, 2027, 7 days after readmission to the licensee a change of condition assessment was completed. The assessment indicated R1 had a Stage II pressure injury wound on his coccyx measuring 3.0 centimeters (cm) by 2.0 cm by 1.5 cm deep with tunneling present. The assessment staging was not accurate according to NPUAP staging guidelines due to the presence of tunneling. The assessment included interventions to offload and reposition R1 every two hours. On April 13, 2026, at 6:04 p.m. and 6:16 p.m. licensee progress notes indicated R1 had developed tunneling in his sacral wound and a new secondary pressure ulcer. The note indicated a nurse would need to complete daily wound care and dressing changes and it could not be delegated. R1's record indicated daily wound care intermediate to be completed by a nurse was scheduled, but was never provided . On April 14, 2026, a licensee's wound assessment monitoring form indicated R1 had a stage II pressure ulcer with tunneling present but failed to identify R1 had developed a new secondary pressure ulcer as indicated in the progress note from April 13, 2026. The assessment lacked measurements, or description of the wound, and the staging was not accurate according to NPUAP staging guidelines due to the presence of tunneling. No other weekly assessment forms were provided prior to this	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 6 indicating weekly wound monitoring was not completed weekly per licensee policy. On April 15, 2026, a licensee wound assessment form indicated R1 had a stage II pressure ulcer measuring 3.0 cm by 2.0 cm, by 1.5 cm deep with tunneling present, but lacked description of the wound and failed to identify R1 had a secondary pressure ulcer. The assessment staging was not accurate according to NPUAP staging guidelines due to the presence of tunneling. The assessment included wound care orders to cleanse the wound with wound cleanser, pat dry, apply Anacept gel packing strip into the wound leaving the tail exposed apply crushed Flagyl on slough of wound after packing was completed, cover with sacral Meplex, peel back Meplex and complete wound care once daily, then change the Meplex every 3 days and as needed (PRN) for saturation/soiling/falling off. R1's service delivery record indicated daily wound care was not implemented/completed or provided as ordered. R2 R2 was admitted to the licensee on December 22, 2025, with diagnoses including sacral wound (prior to admission to the facility), deep vein thrombosis, stroke with left sided hemiparesis (partial weakness or inability to move one side of the body), shoulder impingement, and diabetic neuropathy. A delivery slip dated January 15, 2026, indicated R2 had received an alternating pressure pump and pad for her bed delivered. However, this was not reflected/implemented on R2's assessment or plan of care that she required uses a pressure relieving device or cushions in chair with cut outs for her wounds as ordered by the wound care provider. As a result, the record lacked indication	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 7 the alternating pressure pump and pad were implemented/provided. R2's most recent quarterly assessment dated March 26, 2026, indicated she required one staff assistance with transfers and toileting as requested. The assessment skin section indicated R2 had moisture pressure on coccyx. The assessment failed to identify R2 had a pressure ulcer. The assessment lacked size, description, staging, or interventions including wound care or wound monitoring to help prevent new or worsening pressure ulcers. The assessment identified R2 had a indwelling urinary catheter but failed to include interventions to care for the catheter including providing periurethral cleaning and emptying to help prevent urinary tract infections. On April 24, 2026, a wound assessment form indicated R2 had excoriation on her buttocks that was boggy, macerated, and red with bloody drainage measuring 4.0 cm by 1.5 cm. The assessment failed to identify R2 had a pressure ulcer and lacked any wound treatment plan or interventions. The assessment included a note indicating R2 had a large amount of blood dripping from the scattered maceration and a large blood clot had dislodged from the wound when R2's brief was removed. The note indicated the wound was cleansed, Medi honey was applied, and the wound was covered with a Meplex dressing. The note indicated a lumen from her catheter had caused the injury when it was pulled up into R2's brief then she sat on it. On April 23, 2026, an AVS indicated R2 was seen at the facility by her provider after a catheter lumen was found digging into her buttocks wound. The AVS indicated R1 had several issues	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 8 with her urinary catheter being improperly attached to her wheelchair resulting in the bag dragging on the ground and being pulled, and several episodes of blood in her urine likely related to improper catheter management. On May 4, 2026, a wound assessment form contained the exact information and note detailing the catheter lumen injury and wound care provided on April 24, 2026. As a result, there was no indication wound assessment, or wound care was provided/completed on this day. On May 14, 2026, a licensee provided wound care clinic AVS indicated R2 had two stage III pressure ulcers on her coccyx gluteal area. The left gluteus pressure ulcer measured 10.7 cm by 4.5 cm by 0.1 cm deep, and the right gluteus measured 0.7 cm by 0.7 cm by 0.1 cm deep. The AVS included orders for daily wound care. The orders instructed to wash the wounds with a solution of 1 tablespoon of white vinegar in 1 cup of water, pat dry, apply Mupirocin antibiotic ointment to the wound beds, then apply Triad barrier cream to the periwound areas, and cover with 7X7 Allevyn Life Sacral Dressing over the wounds. The AVS included orders to turn and reposition every 2 hours, use a 3" mattress topper, and pad with moon cut outs where her wounds are for sitting surfaces, and indicated R2 should sleep in her bed not the recliner. R2's record failed to indicate the providers orders were implemented/provided for R2. On May 28, 2026, at 1:10 p.m. (34 days after the last wound assessment) the day after the investigator was onsite and approximately 2 hours after requesting R2's record, an wound assessment was completed. The wound assessment form lacked size/measurement, and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 9 wound description (color, drainage, warmth) to identify if the area was improving worsening or had signs or symptoms of infection. The assessment included wound treatment plan to wash with Acetic wash on bilateral coccyx wound, apply Medi honey to wound bed and zinc cream to surrounding buttocks, and cover with a sacral foam dressing. The assessments wound treatment orders were not accurate according to providers order from the May 14, 2026, wound care clinic AVS. On May 28, 2026, at 1:15 p.m. a licensee provided wound care clinic AVS indicated R2 was again seen for wound care management with a continuation of orders from May 14, 2026, AVS. However, R2's record failed to indicate the providers orders were implemented/provided. The AVS indicated R2 had been seen weekly at the wound clinic for the last 4 weeks. R2's plan of care updated May 28, 2026, after the investigator was onsite indicated she had an indwelling urinary catheter and required assistance from staff with toileting, cleansing, and wiping thought the day as requested. The care plan lacked interventions to care for R2's indwelling urinary catheter to help prevent infections including periurethral cleansing. The plan of care identified R2 had limited bed mobility due to the presence of pressure ulcers, and indicated the facility was waiting for an air mattress. As a result, there was no indication the air bed topper received by the licensee in January 2026,was implemented or in use. The plan of care lacked interventions for assistance with mobility and repositioning to help prevent new or worsening pressure ulcers. The plan of care included wound treatment plan to use acetic wash to bilateral coccyx wound, apply Medi honey	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 10 to wound bed and zinc cream to surrounding buttocks, then apply a sacral foam dressing to be completed by a facility nurse. The plan of care wound treatment plan were not accurate according to providers order from the May 14, 2026, wound care clinic AVS. A ED/hospital AVS dated May 30, 2026, indicated R2 was admitted to the hospital for altered mental state and wound check. R2 was diagnosed with sepsis and required intravenous fluids and antibiotics to treat a pressure ulcer wound infection and urinary tract infection. R2's record reviewed from May 2026, identified ongoing concerns with failure to implement providers orders, accurately/timely wound assessment, provision of wound care, and failure to provide necessary care and services based on a standard of care and according to providers orders were implemented and consistently provided. As a result, the licensee's lack of care and service not provided to R2 likely contributed to R2's risk of infection and subsequent hospitalization for wound infection and urinary tract infection. On May 27, 2026, at 2:01 p.m. Registered Nurse (RN)-F stated leadership was making changes to ensure assessment were correct/accurate, provide staff education, and communicating expectations about charting and documenting. RN-F indicated nurses were checking to make sure services are being provided and indicated things were improving. RN-F indicated weekly wound assessment and monitoring should be completed weekly to include measurements, and description of the wound like swelling, and drainage.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 11 On May 27, 2026, at 8:30 a.m. and 10:46 a.m. and during email correspondence, licensee leadership including Registered Nurse - Cooperate Licensed Assisted Living Director/Clinical Nurse Supervisor (RN-LALD/CNS)-C, Registered Nurse Director of Nurses (RNDON)-E, and Administrator (Admin)-D stated weekly wound assessment and monitoring should be completed. Leadership stated they had identified systemic issues with lack of assessments, monitoring, and supervision of delegated services and indicated things were improving. Leadership indicated they expected providers orders to implemented timely and indicated nursing should review each AVS to ensure nothing was missed. On June 4, 2026, at 9:09 a.m. Wound Clinic Registered Nurse Clinical Supervisor (RNCNS-WOC)-N stated R2's start of care was April 29, 2026, and the orders on May 14, 2026, and May 28, 2026, had been in place since then. RNCNS-WOC-N indicated R2 had a chronic pressure ulcer wounds on her coccyx that were present prior to admission to the licensee. RNCNS-WOC-N stated R2 had no orders for Medi honey or Meplex since April 29, 2026, since the start of care. RNCNS-WOC-N stated the orders were faxed and communicated to the licensee and expected the orders and interventions to be implemented. RNCNS-WOC-N indicated R2 used a urinary catheter for incontinence management to promote wound healing and expected the licensee to provide catheter care including periurethral cleansing and emptying the collection bag to be provided as a standard of care. RNCNS-WOC-N indicated every assisted living facility has different things they provide, but the licensee had not communication any concerns	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 12 what was ordered would not be implemented or provided for R2 including every 2 hour repositioning and daily wound care. On June 4, 2026, at 12:14 p.m. during a follow up interview with RN-LALD/CNS-C and email communication facility leadership indicated R2 had no home care wound care services provided from April 23, 2026, prior to her hospitalization and indicated the facility was responsible to provide wound care as ordered. RN-LALD/CNS-C indicated they implemented new wound care clinic orders from the AVS dated May 28, 2026, on May 30, 2026, but indicated R2 was hospitalized so they had no documentation those services/orders were provided. Leadership indicated RNDON-E provided wound care in May 2026, according to the orders at that time which included Medi honey and Meplex. RN-LALD/CNS-C indicated they were not aware the wound care clinic orders had not been implemented for the R2's pressure ulcer wounds since the start of care on April 29, 2026, and again indicated nursing staff should review each resident's AVS to ensure all orders are implemented. Leadership indicated catheter care including periurethral cleansing had not been implemented/provided since R2's urinary catheter was initiated sometime in February 2026, and indicated would expect it as a standard of care twice daily to help prevent infections. RN-LALD/CNS-C indicated leadership was doing audit of cares and resident records which identified systemic wide issues indicating staff needed to be retrained to ensure resident needs were met going forward. RN-LALD/CNS-C indicated they were aware and uncovering more systemic issues the more they looked. A licensee policy procedure titled "Assessment,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 13 Reviews, and Monitoring" effective/revised August 15, 2024, indicated nursing assessment by a registered nurse of the residents physical, cognitive needs would be done prior to or on the date the resident moves in which ever is earlier. Section 1. indicates The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. Section 2. indicated if necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. Section 3. indicated 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. Section 4. indicated resident wound assessment and monitoring would be completed once weekly including monitoring of the current treatment plan, efficacy, and communication with provider if changes are recommended. A licensee policy and procedure titled "Medication and Treatment Orders Implementation", dated August 15, 2024, indicated all orders must be implemented within 24 hours of receipt. Section 1) indicated upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 14 within 24 hours. If a Licensed Nurse is not on duty when an order is received, the ULP will a.) Notify licensed nurse within one hour of receipt of order. If licensed nurse is not available, staff will leave voice message on voice mail describing order and the resident involved. b.) If it is at the end of a shift and you have not received direction from the licensed nurse, make certain the next shift knows that a message has been left, what the message is regarding and that you are awaiting direction from the licensed nurse. c.) Orders can only be implemented when in direct contact with the licensed nurse. ULP will NOT implement orders or changes to orders unless in direct contact and instruction with the licensed nurse. d.) The original signed order or faxed order will be placed in a designated place for the nurse to review and sign at the next scheduled licensed nurse visit. Section 3) indicated when appropriate, changes will be made to a resident ' s Service Plan. No additional information was provided. TIME PERIOD TO CORRECT: twenty one (21) days.	01620		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 15 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on record review and interview the licensee failed to ensure 2 of 2 residents (R1 and R2) service plans included accurate up to date current description of the service to be provided, and frequency of each service according to the residents assessment, preferences, and providers orders. Although R1 and R2's service plans included methods of monitoring assessments of the residents, monitoring of staff providing services to the residents, and a contingency plan that included action to be taken if a scheduled service could not be provided there was no indication actions were taken to ensure services were provided to these 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	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 16 client ' s/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). Findings include: R1 R1 was admitted to the licensee on January 26, 2026, with diagnoses including polyneuropathy (damage of nerves which can cause numbness, tingling, or burning pain), moderate dementia with other behavioral disturbance, pain in left and right shoulders, stroke with right sided weakness, and generalized muscle weakness. R1's service plan indicated facility staff were trained to provide the services, treatments, and therapies listed in the service plan. The service plan included: - Incontinence Management Program 10 times daily - initiated on February 22, 2026, by ULP staff. - Incontinence Management Program, to be provided daily (no frequency provided), initiated on February 26, 2026, provided by ULP staff. - Medical Monitoring - Skin Condition 1 day per week, initiated on admission, provided by a Registered Nurse (RN). - Daily Repositioning Program initiated February 22, 2026, 12 times daily, provided by ULP staff. - Supervision: Wound care - initiated February 20, 2026, 1 day per week, provided by a RN. - Toileting Assistance - initiated on February 20, 2026, 3 times daily, provided by ULP staff. - Wound care intermediate - initiated on April 13, 2026, to be provided daily by a RN.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 17 - Wound care simple - initiated on April 13, 2026, every 3 days by a RN. The service plan indicated the RN would directly supervise staff performing delegated nursing task within 30 days after staff begins work and further frequency of supervision will be determined based on the individual staff person's performance on the needs and condition of the resident, type of services being performed and the experience of the staff. The Service Plan contingency plan indicated Essential Services: In the event that services which are essential for medical or safety reasons cannot be provided, arrangements acceptable to the resident or responsible person will be made to complete the services. Additionally, Keystone Bluffs will deliver the services by providing a replacement person which may be another member of our unlicensed staff, a member of our licensed staff, or our administrator. Nonessential Services: In the event that services which are not essential for medical or safety reasons cannot be provided, arrangements acceptable to the resident or responsible person will be made to reschedule service. However, there was no indication actions were taken to ensure R1's needs were met for services not provided. R1's Treatment Administration Record (TAR) Resident #1's February 2026 TAR indicated no wound care orders were implemented according to the providers order on February 9, 2026, and none were implemented until February 23, 2026, (4 days after R1 was readmitted from the hospital with wound care orders). Then, "Wound care simple" was scheduled every 3 days (2 days in February 2026) with one day appearing blank with no indication of refusal, and the other day was	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 18 circled/declined indicating R1 had a shower from hospice, but there was no indication wound care was completed by hospice. Resident #1's March 2026 TAR included "Wound care simple "was scheduled every 3 days, not daily according to the February 26, 2026 orders/assessment. The service (scheduled every 3 days) was blank/not provided 8 of the 11 times scheduled with no refusal of care/services documented. The TAR indicated one of 11 scheduled wound care was declined with "hospice nurse" in the notation but there was no indication wound care was provided/completed by the hospice nurse. Resident #1's April 2026 TAR included "Wound care simple" scheduled every 3 days until April 13, 2026. The service was blank, not provided 3 of 5 times scheduled with no refusal of care/services documented. Resident #1's TAR had no daily wound care according to providers orders on April 13, 2026, implemented/provided. R1's Service Delivery Record included: Toileting assistance initiated on February 20, 2026, scheduled AM, PM, and during the night (NOC) shift. The February toileting service record was blank not provided 9 of 23 times scheduled. The March toileting service record was blank not provided 52 of 93 times scheduled. The April toileting service record up to the time of R1's discharge was blank not provided 35 of 51 times scheduled with no refusal of care at those times. Incontinence care initiated on February 22, 2026, scheduled every 2 hours (12 times daily) indicated was blank not provided 37 of 65 times	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 19 scheduled. March incontinence care service was blank not provided 225 of 372 times scheduled. April incontinence care service up to the time of R1's discharge was blank not provided 138 of 204 times scheduled with no refusal of care at those times. Repositioning initiated on February 22, 2026, scheduled every 2 hours (12 times daily) with incontinence care was blank not provided 37 of 65 times scheduled. March repositioning service was blank not provided 230 of 372 times scheduled, with no refusal of care at those times indicating the service was not provided. April repositioning up to the time of discharge was blank not provided 142 of 204 times scheduled with no refusal of care at those times indicating the service was not provided. As a result, there were extended periods of time where repositioning was not offered/provided increasing R1's risk for developing new or worsening pressure ulcers. According to the service delivery record in April after the pressure ulcer worsened and following concerns being reported to the licensee R1 continued to have extended periods of time were repositioning was not offered/provided to help prevent new or worsening pressure ulcers as follows: - On April 1, 2026, no repositioning was provided for no repositioning 20 hours - On April 2, 2026, no repositioning was provided for 12 hours - On April 3, 2026, no repositioning was provided for 20 hours - On April 4, 2026, no repositioning was provided for 20 hours - On April 5, 2026, no repositioning was provided for 20 hours - On April 6, 2026, no repositioning was provided for 20 hours	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 20 - On April 7, 2026, no repositioning was provided for 20 hours - On April 8, 2026, no repositioning was provided for 20 hours - On April 9, 2026, no repositioning was provided for 20 hours - On April 10, 2026, no repositioning was provided for 20 hours - On April 11, 2026, no repositioning was provided for 12 hours - On April 12, 2026, no reposition was provided for 10 hours - On April 13, 2026, no repositioning was provided for 20 hours - On April 14, 2026, no repositioning was provided for 24 hours - On April 15, 2026, no repositioning was provided for 24 hours - On April 16, 2026, no repositioning was provided for 16 hours - On April 17, 2026, no repositioning was provided for 19 hours prior to the resident being transferred to another facility Medical Monitoring Skin Condition indicated weekly skin monitoring should be completed, and any general skin concerns would be communicated to R1's provider initiated on admission. The service was never completed or provided in January, February, March, or April 2026, with no refusal of care. Wound Care Simple initiated February 23, 2026, and ending on April 16, 2026, scheduled every 3 days. The service included instructions to cleanse with wound cleanser, pat dry, apply skin prep/barrier film, and cover with Sacral Mepilex. (Same sacral Mepilex will cover both sacral wounds). Change every 3 days and as needed for soiling/saturation/falling off . The scheduled	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 21 service was blank 8 of 11 times scheduled in March 2026, indicating wound care was not provided or refused those days and declined 1 of 11 times scheduled in March. The scheduled service was blank 4 of 6 times scheduled indicating wound care was not provided or refused those days. Wound Care Intermediate initiated April 14, 2026, included wound care instructions for a nurse to cleanse with Anacept spray, pat dry. apply Anacept gel to packing strip and place into wound leaving a tail. Apply crushed Flagyl on slough of wound after packing completed. Cover with sacral Mepilex. Peel back Mepilex and complete wound care once daily. Apply barrier cream to buttock excoriations BID around dressings and change R1's Mepilex every 3 days and as needed for saturation/soiling/falling off. The service for daily wound care was scheduled but never completed/provided with no refusal of care documented. As a result, R1 never received daily wound care as ordered from April 13, 2026, till discharge on April 16, 2026. Although R1's record showed he occasionally refused services, the service record indicated the services were frequently blank indicating they were not provided or offered to R1 rather than that he was resistant to cares services and refused. The record lacked documentation that supervision of delegated tasks for toileting, incontinence care, repositioning, and dressing changes was provided to ensure they were completed, and there was no indication any action was taken to ensure the needs of the resident were met if a service was not provided. On May 27, 2026, at 11:53 a.m. ULP-H stated staff were supposed to log into Residex (a	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 22 computer electronic medical record system) to get the scheduled service tasks for their assigned tasks for each resident. ULP-H indicated often times staff do not log into Residex to obtain their assigned tasks and never document completing them. ULP-H indicated staff provided cares for residents by habit and memory not necessarily the assigned tasks that were scheduled. ULP-H stated R1 was very compliant when he was offered care and services and only refused if he was in severe pain. ULP-H indicated she had observed concerns that R1's services not provided including being soaked saturated in urinary incontinence with dried dark rings indicating R1 had sat in it for a while. ULP-H indicated R1 did not refuse to go to his bed but preferred his recliner. ULP-H indicated they had filed grievances complaints about R1 not getting cares he was supposed to but nothing ever happened. ULP-H indicated they had received training on documenting in the resident record, but indicated resident care plans and services were inaccurate and had tasks assigned that staff did not do. On May 27, 2026, at 12:26 p.m. ULP-I stated she passed medications, provided simple wound care, and tasks delegated by the nurses. ULP-I indicated the task list sometimes was missing things needed. ULP-I stated R1 was not on her list for wound care, and denied being aware R1 was on scheduled repositioning and incontinence care. ULP-I indicated she knew R1 was frequently saturated with urinary incontinence. ULP-I stated R1 was always cooperative, compliant and appreciative of care and services offered. ULP-I stated R1 was not getting much care or what he needed. ULP-I indicated leadership was working to improve things with other residents.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 23 On May 27, 2026, at 12:57 p.m. ULP-J stated R1 was fairly independent on admission then after his hospital stay needed check and repositioning. ULP-J stated R1 was easy going and never refused cares. ULP-J stated R1 would sleep in his bed if it was offered and was cooperative with repositioning. ULP-J stated they had plenty of concerns R1 was not getting the care and services he needed because he would be completely saturated with urinary incontinence at the start of a shift and it was obvious he had been sitting in it for a long time. ULP-J stated R1 had dried incontinent fecal matter a couple of time indicating every 2 hours checks were not being done. ULP-J stated R1 was cleaned up and changed on a Friday and would be in the exact same clothing which was very dirty the following Monday. ULP-J indicated concerns were reported to leadership but nothing changed. ULP-J indicated R1 would go 16 or more hours at a time without being moved or having any incontinence cares provided. ULP-J indicated they had reported R1 was being neglected to leadership but nothing changed. ULP-J stated they were angry R1 was neglected and no one listened. On May 27, 2026, at 1:20 p.m. ULP-K stated documentation was an issue at the licensee. ULP-K indicated R1 was cooperative with cares and services and indicated he would not have reported concerns of neglect. ULP-K indicated they would report concerns of neglect to leadership. On May 27, 2026, at 1:28 p.m. ULP-L stated hospice reported concerns R1 was not being provided incontinence cares or repositioned. ULP-L indicated she had smelled old incontinence and observed R1 saturated in urine	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 24 or with dried fecal matter indicating he had not received incontinence care. ULP-L indicated concerns were reported but not followed up on when R1 was here, but things were improving. On May 27, 2026, at 1:41 p.m. ULP-M stated R1 was frequently soaked in urine head to toe. ULP-M stated other shifts would not check on R1, and indicated they were not sure if anyone ever asked if R1 wanted to sleep in his bed but rather just left R1 in his chair. ULP-M indicated R1 was always cooperative with cares and services when offered. ULP-M indicated leadership was working on making things better for other residents. On May 27, 2026, at 2:01 p.m. Registered Nurse (RN)-F stated she heard R1 was not compliant and refused cares and to sleep in his bed. RN-F stated leadership was making changes to ensure assessment were correct/accurate, provide staff education, and communicating expectations about charting and documenting. RN-F indicated nurses were checking to make sure services are being provided and indicated things were improving. RN-F indicated weekly wound assessment and monitoring should be completed weekly to include measurements, and description of the wound like swelling, and drainage. On June 4, 2026, at 1:29 p.m. Hospice Licensed Social Worker (HLSW)-A stated they brought concerns with care and service not being provided to leaderships attention but they were defensive and indicated services were not provided because R1 had refused. On June 5, 2026, at 10:47 a.m. Hospice Registered Nurse (HRN)-B stated R1's pressure ulcer worsened quickly due to the lack of incontinence care, repositioning, and wound care	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 25 from the facility causing R1 to have increased pain and suffering at the end of his life. HRN-B indicated the pressure ulcer worsening was related to neglect of cares not the dying process. HRN-B indicated they reported concerns that care and services including repositioning, incontinence cares, and wound care were not being provided to leadership who expressed concern, but nothing changed so R1 was moved to a different facility. When interviewed R1's family stated they had concerns R1 was not getting toileting, incontinence cares, and repositioned and had reported their concern to leadership who expressed concern but nothing changed so they moved R1 to another facility to ensure he would get the care he needed during the end of his life. On May 27, 2026, at 8:30 a.m. and 10:46 a.m. and during email correspondence, licensee leadership including Registered Nurse - Cooperate Licensed Assisted Living Director/Clinical Nurse Supervisor (RN-LALD/CNS)-C, Registered Nurse Director of Nurses (RNDON)-E, and Administrator (Admin)-D stated they were aware of the concerns that care and services were not provided for R1 and indicated they had made changes and were working to improve the provision of care and documentation for all residents. RNDON-E and RN-LALD/CNS-C stated weekly wound assessment and monitoring should be completed, and indicated nursing were monitoring service tasks delegated to unlicensed personnel (ULP) to ensure they were completed. Leadership indicated during the time R1 was under the licensee care nurses were under the impression someone else was doing R1's wound care, assessments, and monitoring. Leadership stated	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 26 they had identified systemic issues with lack of assessments, monitoring, and supervision of delegated services and indicated things were improving. Leadership indicated they expected providers orders to implemented timely and indicated nursing should review each AVS to ensure nothing was missed. R2 On May 28, 2026, at 11:28 a.m. during email communication to licensee leadership R2's May 2026, record was requested and reviewed for correction following identified concerns after R1's stay. R2 was admitted to the licensee on December 22, 2025, with diagnoses including sacral wound (prior to admission to the facility), deep vein thrombosis, stroke with left sided hemiparesis (partial weakness or inability to move one side of the body), shoulder impingement, and diabetic neuropathy. R2's service plan indicated facility staff were trained to provide the services, treatments, and therapies listed in the service plan. The service plan included: - Empty urinary catheter drainage bag, daily at 3:00 a.m., 11:00 a.m., and 4:00 p.m., completed by ULP staff - Special Skin Care, daily AM and PM, completed by ULP staff - Supervision with catheter care, 1 time weekly, complated by the RN - Supervision with wound care, daily AM and PM, completed by the RN The service plan indicated the RN would directly supervise staff performing delegated nursing task within 30 days after staff begins work and further	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 27 frequency of supervision will be determined based on the individual staff person's performance on the needs and condition of the resident, type of services being performed and the experience of the staff. The Service Plan contingency plan indicated Essential Services: In the event that services which are essential for medical or safety reasons cannot be provided, arrangements acceptable to the resident or responsible person will be made to complete the services. Additionally, Keystone Bluffs will deliver the services by providing a replacement person which may be another member of our unlicensed staff, a member of our licensed staff, or our administrator. Nonessential Services: In the event that services which are not essential for medical or safety reasons cannot be provided, arrangements acceptable to the resident or responsible person will be made to reschedule service. However, there was no indication actions were taken to ensure R2's needs were met for services not provided. R2's Service Delivery Record included: Wound Care Simple for May 2026, had instructions for staff to cleanse R2's abdominal folds with soap and water, pat dry, and place a pillow case in half making sure to get into the deepest parts of the fold, report any signs or symptoms of infection including odor, chills, swelling, warmth, or drainage to the nurse. This service record lacked orders/direction for wound care of R2's pressure ulcers. Special Skin Care for May 2026, had instructions to apply Triad to buttocks, coccyx, and inner thigh per MD orders, if open area or if skin seems dark alert the nurse to check, scheduled morning and evening. The service was blank not provided 39	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 28 of 56 times scheduled in May, with no refusal of care documented on those days. The instructions failed to include direction to apply Triad to the R2's peri wound area or change R2's dressing daily according to providers orders, indicating daily wound care was never implemented or provided in May 2026 as ordered. Mobility assistance with transfers reviewed for May 2026, was not implemented until May 27, 2026, after the investigator was onsite as a result there was no indication this service was provided to R2 as assessed indicated. In addition, R2 had no repositioning offloading implemented/provided as ordered every two hours in May 2026. Empty Catheter service for May 2026, included instructions to empty R2's drainage bag scheduled 3 times daily each shift. The service was blank 41 of 87 times scheduled, with no refusal of care on those days. R2's progress notes included documentation on May 20, 2026, and May 22, 2026, of instances when R2's Foley bag was not being emptied and being to the point of almost bursting pat 2000 milliliters (ml) because the previous shifts had not emptied it in May 2026. Supervision with catheter care scheduled weekly was blank never completed/provided with no refusal in May 2026 Supervision wound care scheduled every AM and PM daily was blank never completed/provided with no refusal in May 2026. R2's service delivery record lacked documentation of provision or instruction to provide any wound care for the resident's chronic coccyx pressure ulcers in May 2026. Although the	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 29 progress notes indicated some wound care was provided by the licensee (3 times in May 2026) on May 4, 2026, May 14, 2026, and May 21, 2026, the documentation indicated wound care was completed with Medi honey and Meplex as a result there was no indication the providers orders for daily wound care were followed implemented as ordered. On June 4, 2026, at 9:09 a.m. Wound Clinic Registered Nurse Clinical Supervisor (RNCNS-WOC)-N stated R2's start of care was April 29, 2026, and the orders on May 14, 2026, and May 28, 2026, had been in place since then. RNCNS-WOC-N indicated R2 had a chronic pressure ulcer wounds on her coccyx that were present prior to admission to the licensee. RNCNS-WOC-N stated R2 had no orders for Medi honey or Meplex since April 29, 2026, since the start of care. RNCNS-WOC-N stated the orders were faxed and communicated to the licensee and expected the orders and interventions to be implemented. RNCNS-WOC-N indicated R2 used a urinary catheter for incontinence management to promote wound healing and expected the licensee to provide catheter care including periurethral cleansing and emptying the collection bag to be provided as a standard of care. RNCNS-WOC-N indicated every assisted living facility has different things they provide, but the licensee had not communication any concerns what was ordered would not be implemented or provided for R2 including every 2 hour repositioning and daily wound care. On June 4, 2026, at 12:14 p.m. during a follow up interview with RN-LALD/CNS-C and email communication facility leadership indicated R2 had no home care wound care services provided	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 30 from April 23, 2026, prior to her hospitalization and indicated the facility was responsible to provide wound care as ordered. RN-LALD/CNS-C indicated they implemented new wound care clinic orders from the AVS dated May 28, 2026, on May 30, 2026, but indicated R2 was hospitalized so they had no documentation those services/orders were provided. Leadership indicated RNDON-E provided wound care in May 2026, according to the orders at that time which included Medi honey and Meplex. RN-LALD/CNS-C indicated they were not aware the wound care clinic orders had not been implemented for the R2's pressure ulcer wounds since the start of care on April 29, 2026, and again indicated nursing staff should review each resident's AVS to ensure all orders are implemented. Leadership indicated catheter care including periurethral cleansing had not been implemented/provided since R2's urinary catheter was initiated sometime in February 2026, and indicated would expect it as a standard of care twice daily to help prevent infections. RN-LALD/CNS-C indicated leadership was doing audit of cares and resident records which identified systemic wide issues indicating staff needed to be retrained to ensure resident needs were met going forward. RN-LALD/CNS-C indicated they were aware and uncovering more systemic issues the more they looked. On June 4, 2026, at 11:46 a.m. ULP-P indicated she was a newer employee and described wiping down the catheter tubing with alcohol wipes but denied being aware catheter cares including periurethral cleansing should be done. ULP-P indicated she had not received training to do that at the licensee. ULP-P stated she had never provided catheter care, toileting assistance, repositioning, or assistance with transfers for R2	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 31 and indicated R2 was independent. On June 4, 2026, at 10:15 a.m. ULP-O stated they had never provided periurethral catheter cleansing for R2, and only emptied the drainage bag. ULP-O stated the drainage bag was observed overflowing to the point of bursting on several occasions because other shifts were not emptying it. ULP-O indicated R2 was independent with transfers and mobility and did not get assistance with repositioning. On June 4, 2026, at 10:07 a.m. R2's primary care provider indicated expected the facility to provide catheter care including periurethral cleansing and emptying the urine collection bag regularly to help reduce the risk of infections as a standard of care. R2's record reviewed from May 2026, identified ongoing concerns with failure to implement/providers wound care, and ensure necessary care and services based on a standard of care and according to providers orders were implemented and consistently provided indicating concerns with systemic failure. The record lacked documentation that supervision of delegated tasks for repositioning, and wound care/dressing changes was provided to ensure they were completed, and there was no indication any action was taken to ensure the needs of R2 were met if a service was not provided. A licensee policy and procedure titled "Service Plan", dated August 15, 2024, indicated all residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 32 preferences. A Service Plan means the written plan between a resident or resident's designated representative and the facility about the services that will be provided to the resident. Section 6. indicated the licensee would provide all services indicated in the service plan. The policy indicated the service plan would include: Section a. a description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes actions to be taken if scheduled services cannot be provided. A licensee policy and procedure titled "Supervision of Staff-Delegated Services", dated October 23, 2024, indicated delegated nursing or therapy tasks to residents will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability perform the tasks. Supervision will include observation of the staff administering the medication or treatment and the interaction with resident. A licensee policy and procedure titled "Medication and Treatment Orders Implementation", dated August 15, 2024, indicated all orders must be implemented within 24 hours of receipt. Section 1) indicated upon receipt of a medication and/or	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	Continued From page 33 treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. If a Licensed Nurse is not on duty when an order is received, the ULP will a.) Notify licensed nurse within one hour of receipt of order. If licensed nurse is not available, staff will leave voice message on voice mail describing order and the resident involved. b.) If it is at the end of a shift and you have not received direction from the licensed nurse, make certain the next shift knows that a message has been left, what the message is regarding and that you are awaiting direction from the licensed nurse. c.) Orders can only be implemented when in direct contact with the licensed nurse. ULP will NOT implement orders or changes to orders unless in direct contact and instruction with the licensed nurse. d.) The original signed order or faxed order will be placed in a designated place for the nurse to review and sign at the next scheduled licensed nurse visit. Section 3) indicated when appropriate, changes will be made to a resident's Service Plan. No additional information was provided. TIME PERIOD TO CORRECT: twenty one (21) days.	01650		
02310 SS=H	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 34 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide appropriate care and services based on resident needs and according to and up-to date service plan subject to accepted health care standards for 2 of 2 residents (R1 and R2) reviewed for maltreatment with pressure ulcer wound care. Actual harm occurred for both R1 and R2 reviewed. R1 was harmed when the facility failed to provide weekly skin monitoring as indicated in his services per admission orders and as a result, the licensee failed to identify R1 had developed a pressure injury. Then, when R1's provider identified R1 had a pressure ulcer during a routine visit the licensee failed to implement orders for wound care, pain management, and interventions to help prevent new and worsening pressure ulcers. R1 was transferred to the emergency department (ED) and hospitalized with uncontrolled pain. R1 returned to the facility 6 days later with Hospice for end of life care and wound care orders. However, the licensee failed to ensure service including toileting, repositioning, and wound care were consistently provided causing R1's pressure ulcer to progress from a stage II superficial pressure ulcer to a stage III pressure ulcer with tunneling and R1 developed a new secondary pressure ulcer. Due to the lack of provision of necessary care and services R1 was transferred to another care facility during the end of his life were he died a few weeks later. R2 was harmed when the facility failed to implement providers orders for wound care and ordered interventions to help prevent new worsening pressure ulcers. Although R2 received weekly wound care from the wound clinic the licensee failed to provide daily dressing changes as ordered, weekly wound assessment and monitoring per policy, and failed	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 35 to ensure care/services were implemented/provided as assessed/ordered and based on a standard of care. R2 had an indwelling catheter for incontinence management to promote pressure ulcer wound healing but the licensee failed to implement indwelling urinary catheter cares including periurethral cleansing and failed to ensure drainage bag emptying to help prevent catheter associated urinary tract infections was implemented/provided. Harm occurred when R2 was hospitalized with sepsis from a pressure ulcer wound infection and urinary tract infection, as a result of the neglect. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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). Findings include: The licensee Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated the facility provided wound care basic and complex in collaboration with hospice and/or homecare. UDALSA indicated they provided indwelling urinary catheter care and emptied drainage bags. The UDALSA indicated they also provided end of life care, incontinence care, chair, and bed mobility assistance. The National Pressure Ulcer Advisory Panel (NPUAP) defined a Stage II pressure ulcer as a superficial partial thickness skin loss involving the dermis and/or epidermis. The ulcer presents as a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 36 abrasion, blister, or shallow shiny or dry crater with red/pink wound bed without slough. This stage should NOT be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation. Stage III full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to but not through underlying fascia. The ulcer presents as a deep crater with or without undermining adjacent tissue. Subcutaneous fat loss may be visible, but bone tendon and muscle are not exposed, visible, or palpable. Slough may be present but does not obscure the depth. May include undermining and tunneling. The CDC indicated catheter care included use of appropriate hand hygiene and gloves, properly secure catheters to prevent movement and urethral traction, maintain a sterile closed drainage system, maintain good hygiene at the catheter urethral interface, maintain unobstructed urine flow, maintain drainage bag below the level of the bladder at all times, perform catheter care per facility guidelines, assess the catheter where it enters the meatus for encrusted material or drainage, clean meatus daily during, ensure tubing does not go in and out of the body during cares. Do not clean the periurethral area with antiseptics to prevent catheter associated urinary tract infections (CAUTI) while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate. R1 R1 was admitted to the licensee on January 26, 2026, with diagnoses including polyneuropathy (damage of nerves which can cause numbness, tingling, or burning pain), moderate dementia with other behavioral disturbance, pain in left and right	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 37 shoulders, stroke with right sided weakness, and generalized muscle weakness. On January 27, 2026, R1's admission assessment indicated he required assistance with dressing, transfers, toileting, and personal hygiene. R1's admission skin assessment indicated he had no pressure ulcers present on admission. On January 29, 2026, two days after R1's admission to the licensee, a provider After Visit Summary (AVS) indicated R1 was seen at the facility to establish care and indicated R1 had no wounds present at that time. On February 9, 2026, 11 days later, a provider AVS indicated R1 was seen for a follow and identified R1 had a "NEWLY acquired sacral wound caused by pressure." The AVS indicated R1 described his pain as "unbearable", and that it was "torture to live this way", R1 reported to the provider that staff "forgot about him all the time." The AVS included orders to clean the wound with wound cleanser, pat dry, apply skin prep to peri wound area, and cover with boarder foam dressing 3 times weekly, and PRN for soiling/saturation/or falling off. The orders included Dilaudid (a narcotic pain medication) 1 milligram (mg) twice daily (BID) and BID as needed (PRN)., and Duloxetine (medication used to treat pain, anxiety, and depression) 20 mg daily. With a referral to home healthcare nursing to evaluate, manage, and treat R1's pressure ulcer. However, R1's record indicated these orders were for wound care, referral for wound management, and pain management/medication orders were never implemented. On February 10, 2026, the day after R1 was seen	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 38 by his provider, the licensee completed a 14-day post admission assessment, with no changes noted. The assessment failed to identify that R1 had developed a pressure ulcer or had new orders for wound care or pain medication to help manage his pain. On February 13, 2026, a facility progress note indicated R1 reported uncontrolled pain stating he "wanted to end it all and die." The note indicated R1 was transferred to the emergency department (ED) and was subsequently admitted to the hospital. A hospital AVS indicated R1 was hospitalized for confusion and intractable pain from February 13, 2026, to February 19, 2026, and discharged back to the facility on February 19, 2026, (6 days later). The AVS discharge instructions included orders for wound care with instructions to clean with saline and gauze and apply a Meplex border dressing every 3 days, however those orders were not implemented until 4 days later, then were not completed/provided as scheduled. On February 20, 2026, the day after R1 was readmitted to the licensee from the hospital. An assessment indicated R1 was admitted to hospice for end-of-life care. The assessment indicated R1 was dependent on staff for dressing, required two staff and a mechanical standing lift for transfers, and was incontinent of bowel and bladder. The assessment indicated R1 had a Stage II pressure ulcer partial thickness on his coccyx. The assessment lacked measurements or description of the wound and had no interventions including wound care/monitoring, incontinence management, or repositioning/offloading to help prevent new or worsening pressure ulcers.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 39 On February 22, 2026, 2 days later a progress note indicated concerns with failure to provide toileting incontinence cares was reported after finding R1 soaked though with urinary incontinence during a hospice visit. The note indicated every 2-hour incontinence care and repositioning were then scheduled on R1's services for staff to implement. On February 26, 2027, 7 days after readmission to the licensee a change of condition assessment was completed. The assessment indicated R1 had a Stage II pressure injury wound on his coccyx measuring 3.0 centimeters (cm) by 2.0 cm by 1.5 cm deep with tunneling present. The assessment staging was not accurate according to NPUAP staging guidelines due to the presence of tunneling. The assessment included interventions to offload and reposition R1 every two hours. On March 26, 2026, a complaint/grievance form indicated the facility was made aware of concerns R1's needs for repositioning were not being provided. The complaint indicated the family was educated that R1 wanted to sleep in his recliner, not in his bed, and micro shifting while R1 was in his recliner was provided. On April 4, 2026, a progress note indicated R1 was found on the floor covered with incontinent stool. Around the same time the progress notes indicated hospice reported concerns with R1 was not being repositioned and was not sleeping in his bed. The notes indicated education was provided on repositioning if R1 chose to sleep in his recliner and indicated R1 had refused services and indicated refusal of care was being added to R1's services for staff to document R1's refusals.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 40 However, R1's record lacked documentation R1 had routinely refused or was not compliant with cares/services being offered. On April 7, 2026, providers wound care orders for R1's sacral wound included direction to cleanse the area with soap and water, pat dry, and apply zinc based moisture barrier twice daily with cares and as needed (PRN). The orders indicated the greatest help for this area was offloading, please assist R1 to reposition often. On April 8, 2026, a facility progress note indicated R1 had increased staging on his coccyx pressure ulcer and indicated the licensee nurse would check R1's services daily to ensure they were being provided. The note again indicated R1 had routinely refused services, but the record lacked documentation to show R1 had refused services or why the services were not being provided. The record lacked documentation the licensee had provided daily supervision of tasks delegated to ensure they were provided/completed as indicated in the progress note. On April 13, 2026, at 8:00 a.m. providers wound care orders included instructions for daily wound care as follows: 1) Cleanse with normal saline or wound cleanser, pat dry, 2) Apply skin prep barrier to surrounding skin for both pressure ulcers, 3) Apply boarder foam dressing to proximal sacral pressure ulcer that is currently unstageable, 4) Pack with Anacept moistened packing strip leaving a 2 inch tail out, 5) Apply crushed Flagyl (antibiotic for infection) to visible slough covered wound bed, 6) Cover with foam dressing, 7) Apply barrier cream to buttocks excoriation BID around dressings. On April 13, 2026, at 6:04 p.m. and 6:16 p.m.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 41 licensee progress notes indicated R1 had developed tunneling in his sacral wound and a new secondary pressure ulcer. The note indicated a nurse would need to complete daily wound care and dressing changes and it could not be delegated. R1's record indicated daily wound care intermediate to be completed by a nurse was scheduled, but was never provided . On April 14, 2026, a licensee's wound assessment monitoring form indicated R1 had a stage II pressure ulcer with tunneling present but failed to identify R1 had developed a new secondary pressure ulcer as indicated in the progress note from April 13, 2026. The assessment lacked measurements, or description of the wound, and the staging was not accurate according to NPUAP staging guidelines due to the presence of tunneling. No other weekly assessment forms were provided prior to this indicating weekly wound monitoring was not completed per licensee policy. On April 15, 2026, a licensee wound assessment form indicated R1 had a stage II pressure ulcer measuring 3.0 cm by 2.0 cm, by 1.5 cm deep with tunneling present, but lacked description of the wound and failed to identify R1 had a secondary pressure ulcer. The assessment staging was not accurate according to NPUAP staging guidelines due to the presence of tunneling. The assessment included wound care orders to cleanse the wound with wound cleanser, pat dry, apply Anacept gel packing strip into the wound leaving the tail exposed apply crushed Flagyl on slough of wound after packing was completed, cover with sacral Meplex, peel back Meplex and complete wound care once daily, then change the Meplex every 3 days and as needed (PRN) for saturation/soiling/falling off. R1's record indicated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 42 daily wound care was not implemented/completed or provided as ordered on April 13, 2026. On April 16, 2026, a discharge summary indicated R1 was transferred to another facility for a higher level of care. However, the licensee UDALSA indicates the care and services R1 needed were able to be provided by the licensee. R1's Medication Administration Record (MAR) Resident #1's MAR for February 2026, indicated providers orders for Dilaudid were not initiated/implemented on February 9, 2026, and were not on the resident's MAR for staff to administer until after R1's readmission from the hospital and subsequent hospice admission, and indicated the Duloxetine orders were never implemented/provided. R1's Treatment Administration Record (TAR) Resident #1's February 2026 TAR indicated no wound care orders were implemented according to the providers order on February 9, 2026, and none were implemented until February 23, 2026, (4 days after R1 was readmitted from the hospital with wound care orders). Then, "Wound care simple" was scheduled every 3 days (2 days in February 2026) with one day appearing blank with no indication of refusal, and the other day was circled/declined indicating R1 had a shower from hospice, but there was no indication wound care was completed by hospice. Resident #1's March 2026 TAR included "Wound care simple "was scheduled every 3 days, not daily according to the February 26, 2026 orders/assessment. The service (scheduled every 3 days) was blank/not provided 8 of the 11 times scheduled with no refusal of care/services	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 43 documented. The TAR indicated one of 11 scheduled wound care was declined with "hospice nurse" in the notation but there was no indication wound care was provided/completed by the hospice nurse. Resident #1's April 2026 TAR included "Wound care simple" scheduled every 3 days until April 13, 2026. The service was blank, not provided 3 of 5 times scheduled with no refusal of care/services documented. Resident #1's TAR had no daily wound care according to providers orders on April 13, 2026, implemented/provided. R1's Service Delivery Record included: Toileting assistance initiated on February 20, 2026, scheduled AM, PM, and during the night (NOC) shift. The February toileting service record was blank not provided 9 of 23 times scheduled. The March toileting service record was blank not provided 52 of 93 times scheduled. The April toileting service record up to the time of R1's discharge was blank not provided 35 of 51 times scheduled with no refusal of care at those times. Incontinence care initiated on February 22, 2026, scheduled every 2 hours (12 times daily) indicated was blank not provided 37 of 65 times scheduled. March incontinence care service was blank not provided 225 of 372 times scheduled. April incontinence care service up to the time of R1's discharge was blank not provided 138 of 204 times scheduled with no refusal of care at those times. Repositioning initiated on February 22, 2026, scheduled every 2 hours (12 times daily) with incontinence care was blank not provided 37 of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 44 65 times scheduled. March repositioning service was blank not provided 230 of 372 times scheduled, with no refusal of care at those times indicating the service was not provided. April repositioning up to the time of discharge was blank not provided 142 of 204 times scheduled with no refusal of care at those times indicating the service was not provided. As a result, there were extended periods of time where repositioning was not offered/provided increasing R1's risk for developing new or worsening pressure ulcers. According to the service delivery record in April after the pressure ulcer worsened and following concerns being reported to the licensee R1 continued to have extended periods of time were repositioning was not offered/provided to help prevent new or worsening pressure ulcers as follows: - On April 1, 2026, no repositioning was provided for no repositioning 20 hours - On April 2, 2026, no repositioning was provided for 12 hours - On April 3, 2026, no repositioning was provided for 20 hours - On April 4, 2026, no repositioning was provided for 20 hours - On April 5, 2026, no repositioning was provided for 20 hours - On April 6, 2026, no repositioning was provided for 20 hours - On April 7, 2026, no repositioning was provided for 20 hours - On April 8, 2026, no repositioning was provided for 20 hours - On April 9, 2026, no repositioning was provided for 20 hours - On April 10, 2026, no repositioning was provided for 20 hours - On April 11, 2026, no repositioning was provided for 12 hours	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 45 - On April 12, 2026, no reposition was provided for 10 hours - On April 13, 2026, no repositioning was provided for 20 hours - On April 14, 2026, no repositioning was provided for 24 hours - On April 15, 2026, no repositioning was provided for 24 hours - On April 16, 2026, no repositioning was provided for 16 hours - On April 17, 2026, no repositioning was provided for 19 hours prior to the resident being transferred to another facility Medical Monitoring Skin Condition indicated weekly skin monitoring should be completed, and any general skin concerns would be communicated to R1's provider initiated on admission. The service was never completed or provided in January, February, March, or April 2026, with no refusal of care. Wound Care Simple initiated February 23, 2026, and ending on April 16, 2026, scheduled every 3 days. The service included instructions to cleanse with wound cleanser, pat dry, apply skin prep/barrier film, and cover with Sacral Mepilex. (Same sacral Mepilex will cover both sacral wounds). Change every 3 days and as needed for soiling/saturation/falling off . The scheduled service was blank 8 of 11 times scheduled in March 2026, indicating wound care was not provided or refused those days and declined 1 of 11 times scheduled in March. The scheduled service was blank 4 of 6 times scheduled indicating wound care was not provided or refused those days. The service record indicated R1's last dressing change was documented as completed on April 12, 2026, by a ULP staff not a nurse.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 46 Wound Care Intermediate initiated April 14, 2026, included wound care instructions for a nurse to cleanse with Anacept spray, pat dry. apply Anacept gel to packing strip and place into wound leaving a tail. Apply crushed Flagyl on slough of wound after packing completed. Cover with sacral Mepilex. Peel back Mepilex and complete wound care once daily. Apply barrier cream to buttock excoriations BID around dressings and change R1's Mepilex every 3 days and as needed for saturation/soiling/falling off. The service for daily wound care was scheduled but never completed/provided with no refusal of care documented. As a result, R1 never received daily wound care as ordered from April 13, 2026, till discharge on April 16, 2026. R1's record of death indicated he died on May 5, 2026, at another care facility of natural causes related to cerebral vascular accident (stroke), with contributing conditions including atria fibrillation, dementia, and ischemic cardiomyopathy. Although R1's record showed he occasionally refused services, the service record indicated the services were frequently blank indicating they were not provided or offered to R1 rather than that he was resistant to cares services and refused. The record showed there was no change in the provision of care/services after concerns with care and services were reported to the licensee prior to R1 being transferred to another facility. In addition, the record lacked documentation of accurate weekly wound assessment and monitoring completed to include accurate size, description, stage, and failure to provide interventions to help prevent new or worsening pressure ulcers. The record lacked documentation that supervision of delegated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 47 tasks for toileting, incontinence care, repositioning, and dressing changes was provided to ensure they were completed. On May 27, 2026, at 11:53 a.m. ULP-H stated staff were supposed to log into Residex (a computer electronic medical record system) to get the scheduled service tasks for their assigned tasks for each resident. ULP-H indicated often times staff do not log into Residex to obtain their assigned tasks and as a result never document completing them. ULP-H indicated staff provided cares for residents by habit and memory not necessarily the assigned tasks that were scheduled. ULP-H stated R1 was very compliant when he was offered care and services and only refused if he was in severe pain. ULP-H indicated she had observed concerns that R1's services not provided including being soaked saturated in urinary incontinence with dried dark rings indicating R1 had sat in it for a while. ULP-H indicated R1 did not refuse to go to his bed but preferred his recliner. ULP-H indicated they had filed grievances complaints about R1 not getting cares he was supposed to but nothing ever happened. ULP-H indicated they had received training on documenting in the resident record, but indicated resident care plans and services were inaccurate and had tasks assigned that staff did not do. On May 27, 2026, at 12:26 p.m. ULP-I stated she passed medications, provided simple wound care, and tasks delegated by the nurses. ULP-I indicated the task list sometimes was missing things needed. ULP-I stated R1 was not on her list for wound care, and denied being aware R1 was on scheduled repositioning and incontinence care. ULP-I indicated she knew R1 was frequently saturated with urinary incontinence.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 48 ULP-I stated R1 was always cooperative, compliant and appreciative of care and services offered. ULP-I stated R1 was not getting much care or what he needed. ULP-I indicated leadership was working to improve things with other residents. On May 27, 2026, at 12:57 p.m. ULP-J stated R1 was fairly independent on admission then after his hospital stay needed check and repositioning. ULP-J stated R1 was easy going and never refused cares. ULP-J stated R1 would sleep in his bed if it was offered and was cooperative with repositioning. ULP-J stated they had plenty of concerns R1 was not getting the care and services he needed because he would be completely saturated with urinary incontinence at the start of a shift and it was obvious he had been sitting in it for a long time. ULP-J stated R1 had dried incontinent fecal matter a couple of time indicating every 2 hours checks were not being done. ULP-J stated R1 was cleaned up and changed on a Friday and would be in the exact same clothing which was very dirty the following Monday. ULP-J indicated concerns were reported to leadership but nothing changed. ULP-J indicated R1 would go 16 or more hours at a time without being moved or having any incontinence cares provided. ULP-J indicated they had reported R1 was being neglected to leadership but nothing changed. ULP-J stated they were angry R1 was neglected and no one listened. On May 27, 2026, at 1:20 p.m. ULP-K stated documentation was an issue at the licensee. ULP-K indicated R1 was cooperative with cares and services and indicated he would not have reported concerns of neglect. ULP-K indicated they would report concerns of neglect to leadership.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 49 On May 27, 2026, at 1:28 p.m. ULP-L stated hospice reported concerns R1 was not being provided incontinence cares or repositioned. ULP-L indicated she had smelled old incontinence and observed R1 saturated in urine or with dried fecal matter indicating he had not received incontinence care. ULP-L indicated concerns were reported but not followed up on when R1 was here, but things were improving. On May 27, 2026, at 1:41 p.m. ULP-M stated R1 was frequently soaked in urine head to toe. ULP-M stated other shifts would not check on R1, and indicated they were not sure if anyone ever asked if R1 wanted to sleep in his bed but rather just left R1 in his chair. ULP-M indicated R1 was always cooperative with cares and services when offered. ULP-M indicated leadership was working on making things better for other residents. On May 27, 2026, at 2:01 p.m. Registered Nurse (RN)-F stated she heard R1 was not compliant and refused cares and to sleep in his bed. RN-F stated leadership was making changes to ensure assessment were correct/accurate, provide staff education, and communicating expectations about charting and documenting. RN-F indicated nurses were checking to make sure services are being provided and indicated things were improving. RN-F indicated weekly wound assessment and monitoring should be completed weekly to include measurements, and description of the wound like swelling, and drainage. On June 4, 2026, at 1:29 p.m. Hospice Licensed Social Worker (HLSW)-A stated they brought concerns with care and service not being provided to leaderships attention but they were defensive and indicated services were not	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 50 provided because R1 had refused. On June 5, 2026, at 10:47 a.m. Hospice Registered Nurse (HRN)-B stated R1's pressure ulcer worsened quickly due to the lack of incontinence care, repositioning, and wound care from the facility causing R1 to have increased pain and suffering at the end of his life. HRN-B indicated the pressure ulcer worsening was related to neglect of cares not the dying process. HRN-B indicated they reported concerns that care and services including repositioning, incontinence cares, and wound care were not being provided to leadership who expressed concern, but nothing changed so R1 was moved to a different facility. When interviewed R1's family stated they had concerns R1 was not getting toileting, incontinence cares, and repositioned and had reported their concern to leadership who expressed concern but nothing changed so they moved R1 to another facility to ensure he would get the care he needed during the end of his life. On May 27, 2026, at 8:30 a.m. and 10:46 a.m. and during email correspondence, licensee leadership including Registered Nurse - Cooperate Licensed Assisted Living Director/Clinical Nurse Supervisor (RN-LALD/CNS)-C, Registered Nurse Director of Nurses (RNDON)-E, and Administrator (Admin)-D stated they were aware of the concerns that care and services were not provided for R1 and indicated they had made changes and were working to improve the provision of care and documentation for all residents. RNDON-E and RN-LALD/CNS-C stated weekly wound assessment and monitoring should be completed, and indicated nursing were monitoring service	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 51 tasks delegated to unlicensed personnel (ULP) to ensure they were completed. Leadership indicated during the time R1 was under the licensee care nurses were under the impression someone else was doing R1's wound care, assessments, and monitoring. Leadership stated they had identified systemic issues with lack of assessments, monitoring, and supervision of delegated services and indicated things were improving. Leadership indicated they expected providers orders to implemented timely and indicated nursing should review each AVS to ensure nothing was missed. R2 On May 28, 2026, at 11:28 a.m. during email communication to licensee leadership R2's May 2026, record was requested and reviewed for correction following identified concerns after R1's stay. R2 was admitted to the licensee on December 22, 2025, with diagnoses including sacral wound (prior to admission to the facility), deep vein thrombosis, stroke with left sided hemiparesis (partial weakness or inability to move one side of the body), shoulder impingement, and diabetic neuropathy. A delivery slip dated January 15, 2026, indicated R2 had received an alternating pressure pump and pad for her bed delivered. However, this was not reflected/implemented on R2's assessment or plan of care that she required uses a pressure relieving device or cushions in chair with cut outs for her wounds as ordered by the wound care provider. As a result, the record lacked indication the alternating pressure pump and pad were implemented/provided.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 52 R2's most recent quarterly assessment dated March 26, 2026, indicated she required one staff assistance with transfers and toileting as requested. The assessment skin section indicated R2 had moisture pressure on coccyx. The assessment failed to identify R2 had a pressure ulcer. The assessment lacked size, description, staging, or interventions including wound care or wound monitoring to help prevent new or worsening pressure ulcers. The assessment identified R2 had a indwelling urinary catheter but failed to include interventions to care for the catheter including providing periurethral cleaning and emptying to help prevent catheter associated urinary tract infections (CAUTI). On April 23, 2026, an AVS indicated R2 was seen at the facility by her provider after a catheter lumen was found digging into her buttocks wound. The AVS indicated R1 had several issues with her urinary catheter being improperly attached to her wheelchair resulting in the bag dragging on the ground and being pulled, and several episodes of blood in her urine likely related to improper catheter management. On April 24, 2026, a wound assessment form indicated R2 had excoriation on her buttocks that was boggy, macerated, and red with bloody drainage measuring 4.0 cm by 1.5 cm. The assessment failed to identify R2 had a pressure ulcer and lacked any wound treatment plan or interventions. The assessment included a note indicating R2 had a large amount of blood dripping from the scattered maceration and a large blood clot had dislodged from the wound when R2's brief was removed. The note indicated the wound was cleansed, Medi honey was applied, and the wound was covered with a Meplex dressing. The note indicated a lumen	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 53 from her catheter had caused the injury when it was pulled up into R2's brief then she sat on it. On May 4, 2026, a wound assessment form contained the exact information and note detailing the catheter lumen injury and wound care provided on April 24, 2026. As a result, there was no indication wound assessment, or wound care was provided on this day. On May 14, 2026, a licensee provided wound care clinic AVS indicated R2 had two stage III pressure ulcers on her coccyx gluteal area. The left gluteus pressure ulcer measured 10.7 cm by 4.5 cm by 0.1 cm deep, and the right gluteus measured 0.7 cm by 0.7 cm by 0.1 cm deep. The AVS included orders for daily wound care. The orders instructed to wash the wounds with a solution of 1 tablespoon of white vinegar in 1 cup of water, pat dry, apply Mupirocin antibiotic ointment to the wound beds, then apply Triad barrier cream to the periwound areas, and cover with 7X7 Allevyn Life Sacral Dressing over the wounds. The AVS included orders to turn and reposition every 2 hours, use a 3" mattress topper, and pad with moon cut outs where her wounds are for sitting surfaces, and indicated R2 should sleep in her bed not the recliner. R2's record failed to indicate the providers orders were implemented/provided. On May 28, 2026, at 1:10 p.m. (34 days after the last wound assessment) the day after the investigator was onsite and approximately 2 hours after requesting R2's record, an wound assessment was completed. The wound assessment form lacked size/measurement, and wound description (color, drainage, warmth) to identify if the area was improvingworsening or had signs or symptoms of infection. The	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 54 assessment included wound treatment plan to wash with Acetic wash on bilateral coccyx wound, apply Medi honey to wound bed and zinc cream to surrounding buttocks, and cover with a sacral foam dressing. The wound treatment orders were not accurate according to providers order from the May 14, 2026, wound care clinic AVS. On May 28, 2026, at 1:15 p.m. a licensee provided wound care clinic AVS indicated R2 was again seen for wound care management with a continuation of orders from May 14, 2026, AVS. However, R2's record failed to indicate the providers orders were implemented/provided. The AVS indicated R2 had been seen weekly at the wound clinic for the last 4 weeks. R2's plan of care updated May 28, 2026, after the investigator was onsite indicated she had an indwelling urinary catheter and required assistance from staff with toileting, cleansing, and wiping thought the day as requested. The care plan lacked interventions to care for R2's indwelling urinary catheter to help prevent CAUTI including cleansing perineal care and draining the urinary collection bag. The plan of care identified R2 had limited bed mobility due to the presence of pressure ulcers, and indicated the facility was waiting for an air mattress. As a result, there was no indication the air bed topper received by the licensee in January 2026,was implemented or in use. The plan of care lacked interventions for assistance with mobility and repositioning to help prevent new or worsening pressure ulcers. The care plan indicated R2 had pain with dressing changes. The plan of care included wound treatment plan to use acetic wash to bilateral coccyx wound, apply Medi honey to wound bed and zinc cream to surrounding buttocks, then apply a sacral foam dressing to be completed by	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 55 a facility nurse. The plan of care wound treatment plan were not accurate according to providers order from the May 14, 2026, wound care clinic AVS. A ED/hospital AVS dated May 30, 2026, indicated R2 was admitted to the hospital for altered mental state and wound check. R2 was diagnosed with sepsis and required intravenous fluids and antibiotics to treat a pressure ulcer wound infection and urinary tract infection. Service Delivery Record included: Wound Care Simple for May 2026, had instructions for staff to cleanse R2's abdominal folds with soap and water, pat dry, and place a pillow case in half making sure to get into the deepest parts of the fold, report any signs or symptoms of infection including odor, chills, swelling, warmth, or drainage to the nurse. This service record lacked orders/direction for wound care of R2's pressure ulcers. Special Skin Care for May 2026, had instructions to apply Triad to buttocks, coccyx, and inner thigh per MD orders, if open area or if skin seems dark alert the nurse to check, scheduled morning and evening. The service was blank not provided 39 of 56 times scheduled in May, with no refusal of care documented on those days. The instructions failed to include direction to apply Triad to the R2's peri wound area or change R2's dressing daily according to providers orders, indicating daily wound care was never implemented or provided in May 2026 as ordered. Mobility assistance with transfers reviewed for May 2026, was not implemented until May 27, 2026, after the investigator was onsite as a result there was no indication this service was provided	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 56 to R2 as assessed indicated. In addition, R2 had no repositioning offloading implemented/provided as ordered every two hours in May 2026. Empty Catheter service for May 2026, included instructions to empty R2's drainage bag scheduled 3 times daily each shift. The service was blank 41 of 87 times scheduled, with no refusal of care on those days. R2's progress notes included documentation on May 20, 2026, and May 22, 2026, of instances when R2's urinary catheter bag was not being emptied and being to the point of almost bursting pat 2000 milliliters (ml) because the previous shifts had not emptied it in May 2026. Supervision with catheter care scheduled weekly was blank never completed/provided with no refusal in May 2026 Supervision wound care scheduled every AM and PM daily was blank never completed/provided with no refusal in May 2026. R2's service delivery record lacked documentation of provision or instruction to provide any wound care for the resident's chronic coccyx pressure ulcers in May 2026. Although the progress notes indicated some wound care was provided by the licensee (3 times in May 2026) on May 4, 2026, May 14, 2026, and May 21, 2026, the documentation indicated wound care was completed with Medi honey and Meplex as a result there was no indication the providers orders for daily wound care were followed implemented as ordered. On June 4, 2026, at 9:09 a.m. Wound Clinic Registered Nurse Clinical Supervisor (RNCNS-WOC)-N stated R2's start of care was	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 57 April 29, 2026, and the orders on May 14, 2026, and May 28, 2026, had been in place since then. RNCNS-WOC-N stated R2 had no orders for Medi honey or Meplex since April 29, 2026, since the start of care. RNCNS-WOC-N stated the orders were faxed and communicated to the licensee and expected the orders and interventions to be implemented. RNCNS-WOC-N indicated R2 used a urinary catheter for incontinence management to promote wound healing and expected the licensee to provide catheter care including periurethral cleansing and emptying the collection bag to be provided as a standard of care. RNCNS-WOC-N indicated every assisted living facility has different things they provide, but the licensee had not communication any concerns what was ordered would not be implemented or provided for R2 including every 2 hour repositioning and daily wound care. On June 4, 2026, at 10:07 a.m. R2's primary care provider indicated expected the facility to provide catheter care including periurethral cleansing and emptying the urine collection bag regularly to help reduce the risk of infections as a standard of care. On June 4, 2026, at 10:15 a.m. ULP-O stated they had never provided periurethral catheter cleansing for R2, and only emptied the drainage bag. ULP-O stated the drainage bag was observed overflowing to the point of bursting on several occasions because other shifts were not emptying it. ULP-O indicated R2 was independent with transfers and mobility and did not get assistance with repositioning. On June 4, 2026, at 11:46 a.m. ULP-P indicated she was a newer employee and described wiping	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 58 down the catheter tubing with alcohol wipes but denied being aware catheter cares including periurethral cleansing should be done. ULP-P indicated she had not received training to do that at the licensee. ULP-P stated she had never provided catheter care, toileting assistance, repositioning, or assistance with transfers for R2 and indicated R2 was independent. On June 4, 2026, at 12:14 p.m. during a follow up interview with RN-LALD/CNS-C and email communication facility leadership indicated R2 had no home care wound care services provided from April 23, 2026, prior to her hospitalization and indicated the facility was responsible to provide wound care as ordered. RN-LALD/CNS-C indicated they implemented new wound care clinic orders from the AVS dated May 28, 2026, on May 30, 2026, but indicated R2 was hospitalized so they had no documentation those services/orders were provided. Leadership indicated RNDON-E provided wound care in May 2026, according to the orders at that time which included Medi honey and Meplex. RN-LALD/CNS-C indicated they were not aware the wound care clinic orders had not been implemented for the R2's pressure ulcer wounds since the start of care on April 29, 2026, and again indicated nursing staff should review each resident's AVS to ensure all orders are implemented. Leadership indicated catheter care including periurethral cleansing had not been implemented/provided since R2's urinary catheter was initiated sometime in February 2026, and indicated would expect it as a standard of care twice daily to help prevent infections. RN-LALD/CNS-C indicated leadership was doing audit of cares and resident records which identified systemic wide issues indicating staff needed to be retrained to ensure resident needs	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 59 were met going forward. RN-LALD/CNS-C indicated they were aware and uncovering more systemic issues the more they looked. R2's record reviewed from May 2026, identified ongoing concerns with failure to implement providers orders, accurately/timely wound assessment, provide wound care, and ensure necessary care and services based on a standard of care and according to providers orders were implemented and consistently provided indicating concerns with systemic failure. The licensee lack of care and service not provided likely contributed to R2's risk of infection and subsequent hospitalization for wound infection and urinary tract infection. A licensee policy procedure titled "Assessment, Reviews, and Monitoring" effective/revised August 15, 2024, indicated nursing assessment by a registered nurse of the residents physical, cognitive needs would be done prior to or on the date the resident moves in which ever is earlier. Section 1. indicates The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment. Section 2. indicated if necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. Section 3. indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 60 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. Section 4. indicated resident wound assessment and monitoring would be completed once weekly including monitoring of the current treatment plan, efficacy, and communication with provider if changes are recommended. A licensee policy and procedure titled "Service Plan", dated August 15, 2024, indicated all residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident ' s needs and preferences. A Service Plan means the written plan between a resident or resident ' s designated representative and the facility about the services that will be provided to the resident. Section 6. indicated the licensee would provide all services indicated in the service plan. The policy indicated the service plan would include: Section a. a description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes actions to be taken if scheduled services cannot be provided. A licensee policy and procedure titled "Delegation	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 61 of Assisted Living Services", dated October 23, 2024, indicated a Registered Nurse or licensed healthcare professional may delegate tasks only to staff who are competent and possess knowledge and skills consistent with the complexity of the task and according to the appropriate Minnesota practice act. A licensee policy and procedure titled "Supervision of Staff-Delegated Services", dated October 23, 2024, indicated delegated nursing or therapy tasks to residents will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability perform the tasks. Supervision will include observation of the staff administering the medication or treatment and the interaction with resident. A licensee policy and procedure titled "Medication and Treatment Record - documentation and refusal", dated October 23, 2024, indicated the licensee would create and maintain a correct and accurate medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies. The policy indicated if the treatment or therapy is not provided staff must document the reason why it was not done. The policy indicated if a refusal occurred the licensee must discuss with the resident consequences of the refusal and document the discussion in the resident record. A licensee policy and procedure titled "Medication and Treatment Orders Implementation", dated August 15, 2024, indicated all orders must be implemented within 24 hours of receipt. Section	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 62 1) indicated upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours. If a Licensed Nurse is not on duty when an order is received, the ULP will a.) Notify licensed nurse within one hour of receipt of order. If licensed nurse is not available, staff will leave voice message on voice mail describing order and the resident involved. b.) If it is at the end of a shift and you have not received direction from the licensed nurse, make certain the next shift knows that a message has been left, what the message is regarding and that you are awaiting direction from the licensed nurse. c.) Orders can only be implemented when in direct contact with the licensed nurse. ULP will NOT implement orders or changes to orders unless in direct contact and instruction with the licensed nurse. d.) The original signed order or faxed order will be placed in a designated place for the nurse to review and sign at the next scheduled licensed nurse visit. Section 3) indicated when appropriate, changes will be made to a resident's Service Plan. No additional information was provided. TIME PERIOD TO CORRECT: twenty one (21) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29456	A. BUILDING: _____ B. WING _____	C 05/27/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02360	Continued From page 63 by: The licensee failed to ensure two of two residents reviewed (R1 and R2) were free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		