Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report: HL294567422M
Compliance #: HL294567183C

Date Concluded: March 24, 2026

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Not Substantiated

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): The facility neglected the resident when she fell in her bathroom while transferring from the toilet to her wheelchair.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell, the error was an isolated incident, and no harm occurred to the resident.

The investigator conducted interviews with facility staff members, including administrative and unlicensed staff. The investigation included a review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included osteoporosis. The resident's service plan required assistance from one person for transfers into

bed and stand-pivot transfers between the wheelchair and recliner, as well as to-and-from the toilet.

A concern arose when the resident complained of rib pain from a fall, even though she could not recall when and how the fall occurred.

The resident's notes indicated an incident occurred when unlicensed caregiver #1 assisted the resident while transferring from the wheelchair to the bed. During the transfer, the resident was seated at the edge of the bed and began to slip. Unlicensed caregiver #1 cradled the resident and assisted her to the floor next to the bed to prevent injury. After she was assisted to the floor, unlicensed caregiver #1 attempted to lift her back onto the bed using a gait belt and by lifting under her arms. Although he was able to lift her partially, he was unable to turn her or properly position the wheelchair to complete the transfer and safely lowered her back to the floor. A second attempt using the same method was also unsuccessful. Two additional staff members then arrived to assist, making a total of three staff involved. Together, they successfully assisted the resident from the floor into bed.

During an interview, the manager stated that she was not working in manager role at the time and was not heavily involved in the internal investigation. However, she was aware the previous manager spoke with all parties involved and emphasized that, even though it was an assisted fall, it still needed to be reported. She also said the resident's care plan had been updated and sara steady (sit-to-stand device) was utilized for transferring. The manager stated the facility offered to take the resident to the hospital and she refused. X-rays were ordered and result came back with no fractures.

During an interview, unlicensed caregiver #2 stated she heard unlicensed caregiver #1 call for help on the walkie-talkie and arrived to assist. When she arrived, the resident was sitting on the floor and did not appear to be in pain. She believed it was an assisted fall and stated the resident was stable on her feet and her legs could sometimes give out. She also stated after the incident, the care plan was changed, and staff were required to use sara steady when transferring the resident.

During an interview, unlicensed caregiver #3 stated she assisted the other two staff members in getting the resident into bed. She did not witness the fall but, based on what she was told when she arrived, believed it was an assisted fall.

According to the resident's X-ray results, no obvious displaced rib fractures were identified.

During the investigation, despite making multiple attempts, the investigator was unable to reach unlicensed caregiver #1 as he was on leave.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means: An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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: Yes.
Family/Responsible Party interviewed: No, attempted but did not reach.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility initiated an internal investigation and re-educated all staff members on fall procedures, including reporting requirements, notifying a nurse prior to assisting a resident up, requiring a minimum of two people to help a resident off the floor, and clarifying that lowering a resident to the floor is considered a fall. The facility also updated the resident’s care plan.

Action taken by the Minnesota Department of Health: No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 01/22/2026

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 On January 22, 2026, the Minnesota Department of Health initiated an investigation of complaints #HL294567422M/HL294567183C. No correction orders are issued.	0 000		