DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL320453962M
Compliance #: HL320457768C

Date Concluded: September 2, 2025

Name, Address, and County of Licensee Investigated:
Keystone Place at LaValle Fields
14602 Finale Ave N.
Hugo, MN55038
Washington County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

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):
The resident was neglected when facility staff failed to provide the necessary care and services to a cognitively impaired resident. As a result, the facility failed to identify the resident had developed a large serious sacral wound requiring hospitalization and debridement.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure the resident's plan of care directed staff on the residents individualized care needs. Unlicensed staff documented at times the resident would refuse staff assistance, however, nursing failed to follow up on the resident refusals to ensure the resident was receiving assistance with personal cares. The licensed nurse saw the residents sacral wound and transferred the resident to the emergency department. The resident was hospitalized, and required wound debridement, and wound care as a result of the neglect.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), hospital records, facility internal investigation, facility incident reports, and related facility policy and procedures. Also, the investigator observed the resident, the resident's skin/wound, resident cares, and staff at the facility.

The resident resided in an assisted living facility with diagnoses including dementia without behavioral disturbance, and Alzheimer's disease with late onset.

The resident's assessment completed about 2 months prior to the incident indicated the resident had no skin wound concerns. The assessment indicated the resident was cognitively impaired, oriented to herself only, but could understand and be understood. The assessment indicated the resident required toileting assistance as needed per the service plan, required reminders to use the restroom and assistance to use incontinence products before and after sleeping. The assessment indicated the resident required minimal stand by assistance with bathing to get in and out of the shower and to wash her hair and body to ensure cleanliness 2 times weekly.

The resident service/care plan for bathing indicated the resident required stand by assistance in and out of the shower and physical assistance with washing the resident's body and hair as needed 2 times weekly. The service/care plan for toileting indicated staff should provide reminders and assistance as needed to maintain the resident's cleanliness 4 times daily.

The resident's treatment administration record (TAR) included staff direction to provide physical assistance with bathing and indicated staff were to give reminders and stand by assistance twice weekly to ensure the resident's cleanliness. The directions indicated the resident needed help getting in and out of the shower for safety. The resident refused 4 of the 9 times scheduled in April, 7 of the 9 times scheduled in May, and 3 of 3 times scheduled in June prior to the incident. The resident TAR for toileting instructed staff to give the resident toileting reminders and assistance as needed with use of incontinence products to ensure her cleanliness and skin integrity, scheduled 4 times daily. The record indicated the resident refused 24 times in April, 44 times in May, and 13 times in June prior to the day of the incident on June 11, 2025.

The resident's progress notes lacked any documentation of refusals of bathing assistance, toileting reminders/assistance, skin concerns on the resident's sacrum or actions taken.

A facility incident report documented the day of the incident at 3:00 p.m. indicated the resident had a wound on her bottom that went from just above her coccyx down to her perineum. The report indicated the center part of the wound looked to be calloused tissue and around that area was reddened. 911 was called and the resident was transferred by ambulance to the emergency department (ED).

The ED and hospital record indicated the resident was seen for a wound check. The ED and hospital record indicated the resident had a significant large sacral wound with hypertrophic skin (abnormal thickening of the skin) which was surrounded by redness that was warm to the touch. The record indicated the resident was treated for sepsis from wound cellulitis and urinary tract infection. The hospital note indicated based on the severity of the wound present on admission, the wound had likely been present for months. A wound consult note indicated the resident had a thick buildup of tan/beige tissue called psudoverriculous deposits (a skin wound associated with prolonged urinary incontinence and poor hygiene) extending from the resident's sacrum to the groin and labial areas which required wound debridement and wound care. The record indicated the facility reported the resident was incontinent but did not like staff to change her incontinent brief and often refused services.

A facility investigation indicated the cause of the wound found on the resident's buttocks was due to caregiver neglect. The investigation indicated although staff had documented the resident refused assistance with showering and toileting with a history of refusals, the refusals were not investigated. As a result, none of the staff or nurses had observed the residents skin condition prior to the incident to identify the presence of the resident's sacral wound. The facility investigation indicated the incident was avoidable because nursing should have followed up on the resident's refusals but did not.

When interviewed leadership staff indicated they were not aware the resident refused cares and services prior to the incident despite ongoing documentation of refusals in the resident record. Leadership indicated although some staff documented bathing/toileting assistance was provided, the resident had refused to allow staff in the room to assist her, as a result no staff had laid eyes on the resident's skin to identify the sacral wound prior to the incident.

When interviewed nursing staff indicated they were unaware the resident had refused cares and services and were not allowing staff in the room to assist with bathing. Nursing staff indicated they had not observed the resident's skin prior to the incident and were not aware the resident had a wound present until the day of the incident.

When interviewed a hospital case manager (a registered nurse) stated the resident's wound were caused by prolonged exposure to urinary incontinence and poor hygiene. The case manager stated hospital providers and wound care nurses indicated based on the severity and extent of the wound it had likely been present for months and was painful to the resident. The case manager stated the extent of the wound was disturbing, and she had never seen anything like it before. The case manager indicated the resident was not able to make decisions about her care and services due to cognitive impairment, and the resident's medical power of attorney was not aware the resident was refusing services at the facility.

When interviewed several unlicensed staff indicated the resident refused toileting reminders and assistance and would not allow staff to be in the room to assist with bathing or toileting. As

a result, none of the staff had observed the resident's skin prior to the incident. The staff indicated they documented refusals on the TAR for nursing to follow up on. Staff stated facility nursing staff were aware the resident refused assistance prior to the incident because they often discussed the resident's refusals during change of shift with the facility nurses.

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

Action taken by facility:
The facility transferred the resident to the ED for evaluation and treatment of the sacral wound. The facility implemented scheduled physical assistance with toileting, weekly skin monitoring, and ensured wound care was provided for the resident. According to the facility staff and family the resident's wound is currently resolved. In addition, the facility implemented monthly skin monitoring for all residents, and provided education to staff on skin monitoring, refusals of care, and reporting to nursing. The facility also implemented audits of the TAR to monitor, identify, and respond to refusals of care/services in a timely manner.

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
Washington County Attorney
Hugo City Attorney
Hugo Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32045	A. BUILDING: _____ B. WING _____	C 08/13/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER 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: #HL320457768C/#HL320453962M On August 13, 2025, 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 100 residents recieving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL320457768C/#HL320453962M, tag identification 2360.	0 000		
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.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, 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		