

Protecting, Maintaining and Improving the Health of All Minnesotans

# State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL34175001M Date Concluded: May 6, 2022

**Compliance #:** HL34175002C

Name, Address, and County of Licensee Investigated:

Keller Lake Commons
5771 Meadowview Drive
White Bear Lake, MN 55110
Sherburne County

Facility Type: Assisted Living Facility (ALF) Evaluator's Name: Michele R. Larson

Special Investigator

Finding: Substantiated, facility responsibility

#### **Nature of Visit:**

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.

## Allegation(s):

It is alleged: The facility neglected the resident when they failed to reorder the resident's insulin and prescribed eye drop medications in a timely manner, causing the resident to go without being administered medications for days. The resident had corneal transplant surgery and required six different prescribed eye drops to be administered in her eyes several times per day to prevent rejection of the transplanted cornea. In addition, the night before her scheduled corneal transplant surgery, the facility gave the resident the wrong insulin to self-administer. The resident injected several units of insulin before realizing it was the wrong insulin. The resident was up most of the night eating carbohydrates to prevent hypoglycemia (low blood sugar), when she should have been NPO (no food by mouth) prior to surgery.

# **Investigative Findings and Conclusion:**

Neglect was substantiated. The facility was responsible for the maltreatment. Unlicensed personnel (ULP) staff did not administer schedule eye drops before and after the resident's corneal transplant due to nursing staff did not reorder medications in a timely manner. The facility did not follow their own policy on retraining direct care staff after they had several medication errors. Several ULP's passing medications did not have medication training records. In addition, the ULP made a critical insulin error the night prior to the resident surgery by given the resident short acting insulin instead of long-acting insulin requiring the resident to eat food five hours prior to her surgery.

The investigation included interviews with facility staff members, including nursing staff, and unlicensed staff. In addition, the resident and her family members were interviewed. The investigation included review of the resident's facility and external medical records, personnel files, and the facility's policies and procedures.

The resident's medical record was reviewed. The resident's diagnoses included Diabetes Type 1, legal blindness, Fuchs' dystrophy (hereditary eye condition), glaucoma, and macular degeneration. The resident's service plan indicated the resident required assistance with personal cares, toileting, medication assistance, meals, diabetic nail care, and housekeeping. The resident required a walker for mobility. The resident's assessments indicated the resident was alert and oriented and able to make her needs known.

The resident's record indicated on the eve before the resident's corneal transplant eye surgery, unlicensed personnel (ULP) 1 was assisting the resident with her evening cares and medication. ULP 1 gave the resident an insulin pen so the resident could self-administer her nighttime insulin. The resident proceeded to inject the insulin, but realized it was the wrong insulin due to the color of the insulin pen. The resident stopped, but still injected several units of the wrong insulin; her fast-acting insulin instead of her scheduled long-acting insulin. The resident was up until midnight eating carbohydrates to prevent her blood sugar levels from becoming too low. The resident left at 5:00 a.m. to go to her corneal transplant surgery.

The resident's medication administration records (MARs) indicated the resident was prescribed the following eye drops administered several times a day before and after her corneal transplant surgery to prevent rejection of the transplanted cornea: Sodium chloride (one drop to right eye four times per day (QID)), Ketorolac (one drop into right eye two times per day), Moxifloxacin (antibiotic) (one drop into right eye QID), Prednisolone (steroid) acetate (one drop into right eye QID), Restasis (one drop to right eye daily) and artificial tears (one drop into both eyes QID). Staff were directed to wait five minutes in between administer each type of eye drops. In addition, the resident was prescribed an eye ointment, Muro 128 (administer ½ ribbon to right eye) and administered five minutes after last eye drop.

The resident's MARs indicated the resident's missed 32 doses of eye drops before and after her eye surgery due to no supply and missed two doses of the eye ointment due to "declined" and staff not following prescriber's orders.

The resident's record lacked evidence the facility performed medication omission procedures after they failed to administer her medications.

The resident's record indicated approximately three weeks after her corneal transplant surgery, the resident missed three consecutive doses (8:00 p.m., 7:00 a.m., 11:00 a.m.) of moxifloxacin (antibiotic) eye drops, and five consecutive doses (5:00 p.m., 8:00 p.m., 7:00 a.m., 11:00 a.m., 4:00 p.m.) of prednisolone acetate (steroid) eye drops due to the facility not reordering the eye drops in a timely manner.

Review of the facility's medication error reports indicated there were 64 medication errors during a four-month period. Most of the medication errors were documented as "not given," "misread order," and "omission." The following ULP's had more than 3 medication errors in a one-month period: ULP 2: 19 medication errors; ULP 3: 13 medication errors; ULP 4: 3 medication errors; ULP 5: 6 medication errors.

Review of ULP 3, ULP 4, ULP 5's employee records lacked evidence they were retrained on medication administration.

Review of employee records indicated ULP 2 was required to do medication administration retraining due to continued medication errors, giving incorrect doses, and documenting "no supply" when supply was in a cabinet. ULP 2's retraining included completing online training on medication administration and completed three medication passes with a nurse within four days of the disciplinary action. The disciplinary document was completed and signed by registered nurse (RN) 1. Review of ULP 2's training record indicated ULP 2 completed her online retraining over two months after the due date. ULP 2's training record lacked evidence ULP 2 completed her retraining on three medication passes with a nurse. ULP 2 had an additional 13 medication errors after she was disciplined.

During an interview, RN 1 stated staff updated her through their work phones or medication reorder form. RN 1 stated the medication reorder forms were rechecked daily.

During an interview, ULP 1 stated she was distracted the night she gave the resident the wrong insulin. ULP 1 stated she immediately called RN 1 who advised her to monitor the resident through the rest of her evening shift. ULP 1 stated she and another ULP rechecked the resident's blood sugar.

During an interview, ULP 2 stated the resident expected her medications on time and would worry if she did not get them. ULP 2 stated the resident complained if the facility was out of her eye drops for "a while." ULP 2 stated, she knew the eye drops she was supposed to get for her

eye surgery. ULP 2 stated she did not think all the resident's eye drops were out at the same time, but stating, "I'm not sure."

During an interview, family member (FM) 1 stated the facility never informed her after ULP 1 gave the resident the wrong insulin. FM 1 stated RN 1 denied knowing anything about the incident. FM 1 stated there were many times the resident did not get her insulin because staff left the cap on the needle. FM 1 stated the facility ran out of the resident's eye medications two weekends in a row after the resident's corneal transplant surgery. FM 1 stated the resident never received her insulin on time. FM 1 stated she and other family members moved the resident out after the facility ran out of several doses of her eye medications.

During an interview, FM 2 stated the resident moved into the facility because she was legally blind and could no longer take care of herself. FM 2 stated she kept a log with dates and times when the resident did not get her eye medications and insulin. FM 2 stated there were a few times the resident missed her insulin because staff left the cap on the end of the needle, or the resident was not administered an eye medication because RN 1 lost the bottle.

During an interview, the resident stated she moved into the facility because she required daily assistance with her complicated eye medication regimen. The resident stated she was prescribed several different eye drops and eye ointment to be administered before and after her corneal transplant surgery to prevent rejection of her transplanted cornea. The resident stated the night before her early morning eye surgery, ULP 1 gave her the wrong insulin to self-administer. The resident stated once she realized it was the wrong insulin, she had already injected several units of insulin. The resident stated she was up until midnight eating carbohydrates to prevent her blood sugar levels from dropping too low. The resident stated her family moved her out of the facility after the facility ran out of two of her eye medications, causing her to miss eight consecutive doses. The resident stated her corneal transplant surgery did not go well, stating, "my eyesight is still very poor."

In conclusion, 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:

- (a) 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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: Yes. Two family members were interviewed.

Alleged Perpetrator interviewed: Not Applicable.

## Action taken by facility:

The facility held mandatory monthly meetings on topics of medication administration and retrained some unlicensed staff on medication administration.

# Action taken by the Minnesota Department of Health:

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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sherburne County Attorney
Big Lake City Attorney
Big Lake Police Department
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '		(X3) DATE SURVEY COMPLETED	
		34175	B. WING		C <b>02/01/2022</b>
	PROVIDER OR SUPPLIER	655 NORV	DRESS, CITY,  VOOD LANE  MN 55309		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
0 000	In accordance with 144G.08 to 144G.9 issued pursuant to 2 Determination of whom requires compliance provided at the state When a Minnesota items, failure to combe considered lack  INITIAL COMMENT #HL34175002C/#H  On February 1, 202 of Health conducted	PROVIDER LICENSING DER  Minnesota Statutes, section 5, these correction orders are a complaint investigation.  nether a violation is corrected with all requirements ute number indicated below. Statute contains several apply with any of the items will of compliance.  TS:  L34175001M  2, the Minnesota Department of a complaint investigation at	0 000	Assisted Living Provider 144G.  Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living Facilities. The assigned tag number appears in the far left cold entitled "ID Prefix Tag." The state number and the corresponding textstate Statute out of compliance is the "Summary Statement of Deficic column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the evaluation from the properties of the Theorem Please DISREGARD THE HEAD THE FOURTH COLUMN WHICH	oftware. to sted Jumn Statute kt of the listed in lencies" s the le state This las lators' rection.  DING OF
	orders are issued. A investigation, there services under the Assisted Living licer #HL34175002C/#H identification 510, 6	ction orders are issued for		STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES T FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA ST STATUTES.  THE LETTER IN THE LEFT COLUUSED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	THIS ON FOR TATE  JMN IS SES AND EVEL

Minnesota Department of Health

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

(X6) DATE TITLE

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/0	) 1/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309				
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0 510 SS=E		fection control program	0 510				
	(a) All assisted living maintain an infection complies with accepturing standards of (b) The facility's infectonsistent with current national Centers for Prevention (CDC) of control in long-term applicable, for infectors assisted living facility (c) The facility must compliance with this Compliance with this Compliance with this complied with a sand nursing standart to COVID-19. This land residents who rebuilding.  This practice results violation that did not safety but had the president's health or cause serious injury was issued at a patilimited number of rethan a limited number of rethan a limited number.	ction control program must be ent guidelines from the Disease Control and or infection prevention and care facilities and, as tion prevention and control in ties.  It maintain written evidence of a subdivision.  The subdivision of the failed to establish and the infection control program accepted health care, medical, and for infection control related that the potential to affect all esided in the licensee's the dinal level two violation (and the potential to have harmed a safety, but was not likely to an accepted, and the potential to have harmed a safety, but was not likely to a safety, but was not likely to a safety are affected, more the potential to have harmed a safety, but was not likely to a safety are involved, or the performance of staff are involved, or the performance of staff are involved, or the performance of the potential to the potential to the performance of staff are involved, or the performance of the performan					
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Minnesota Department of Health STATE FORM

Minnesota Department of Health

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		R SCREENING to ensure visitors were fully rature checks and COVID-19				
	On February 1, 2022, at 10:00 a.m., the surveyor entered the facility.					
	carpet cleaning persentering the facility temperature or company symptom screening	2, at 10:50 a.m., an outside son (CCP) was observed without stopping to take his pleting the COVID-19 checklist at the entrance door earing any personal ht (PPE).				
	observed not taking	2, at 12:30 p.m., a visitor was her temperature completing otom screening checklist facility.				
	EQUIPMENT & Had The licensee failed was properly disinfer addition, the license sanitizer was located	SUSABLE MEDICAL and Sanitizer to ensure the thermometer ected after each use. In the failed to ensure hand at the entrance table for use before entering the				
	Congregate Care S 21, 2021, indicated cleaned and disinfe	d, COVID-19 Action Plan for ettings, updated December shared equipment should be cted after each use. ts should be easily accessible,				
	entered the facility.	2, at 10:00 a.m., the surveyor Placed on a small table near as a COVID-19 symptom				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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screen checklis	st and a thermometer.				
approached the take the invest thermomter that table. LALD-I of after taking the entrance table and staff to use The licensee till August 1, 2021 system for previnvestigating, of communicable infection control	e investigator and proceeded to igator's temperature using a at was placed on the entrance lid not sanitize the thermometer invesitgaor's temperature. The lacked hand sanitizer for visitors before they entered the facility.  Itled Infection Control, updated, indicated the licensee had a venting, idientifyingm reporting, controlling infections, and diseases. The policy indicated their of program was consistent with so for Disease Control (CDC)				
TIME PERIOD	TO CORRECT: Two (2) days.				
0 620 144G.42 Subd SS=G for reporting m	6 Compliance with requirements	0 620			
for reporting mabuse prevention (a) The assisted the requirement of the first maltreatment of the first maltreatment and the cases of suspections. This MN Requirement by:	Its for the reporting of of vulnerable adults in section acility must establish and ritten procedure to ensure that all ected maltreatment are reported.				
	view and record review, the to comply with the requirements				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
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KELLER	LAKE COMMONS		WOOD LANE E, MN 55309				
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	Center (MAARC) si	neosta Adult Abuse Reporting gnificant medication errors one of three residents (R1) ed.					
	violation that harmed not including serious or a violation that has serious injury, impairs a limited number of real limited number of limit	ed in a level three violation (a ed a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death), and was discope (when one or a esidents are affected or one or staff are involved or the red only occasionally).					
	The findings include	e:					
	to the licensee on A diagnoses included blindness, Fuchs' d	d was reviewed. R1 admitted lugust 27, 2021. R1's Type 1 diabetes, legal ystrophy (hereditary eye degeneration, and glaucoma.					
	indicated R1 received cares, four times day meals, medication a	ated August 28, 2021, ed assistance with personal ally blood glucose checks, assistance, diabetic foot care, and housekeeping. R1 used a					
	September 10, 202 supervision with bar with mobility. R1 was labels due to poor vicorrect number of in by listening to the coverified and supervision.	se (RN) assessment dated 1, indicated R1 required thing, and stand-by assistance as unable to read medication vision. R1 was able to dial the usulin units on her insulin pensilicks on the pens which staff ised. R1 had partial or total assessed as required staff					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		34175	B. WING		l l	C <b>01/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KELLER	LAKE COMMONS		WOOD LANE			
		BIG LAK	E, MN 55309			
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	assistance in the ev	ent of an emergency.				
	dated November 9,	se prevention plan (IAPP) 2021, indicated R1 needed dication administration due to ness.				
	dated October and was prescribed the insulin: sodium chlorinstill one drop into (QID). Must wait five moxifloxacin ophthat drop into right eye to prednisolone acetal instill one drop into minutes between dinstill one drop BID week, then one drop begin drops three do October 13, 2021; If apply 1/2 inch ribbot administered after I administer one drop 8-12 Units, resident per day (TID), staff (long-acting insulin)	November 2021, indicated R1 following eye drops and oride ophthalmic solution, 5%, right eye four times per day e minutes between drops; almic solution, 0.5%, instill one wo times per day (BID); te ophthalmic solution 1%, right eye QID. Must wait five ifferent drops; ketorolac 0.5%; in post-operative eye for one p daily for seven more weeks, lays before surgery on Muro 128 5% eye ointment, on to right eye daily, must be ast eye drop; Restasis, o into right eye daily novalog to self-administer three times to verify dose; basaglar 30 Units, resident to e daily (8:00 p.m.), staff to				
	Medication Administration did not receive her dates:  *September 1-16, 2 ophthalmic solution supply	ctober, and November 2021 stration Summary, indicated R1 eye drops on the following 2021, 8:00 p.m.: Ketorolac -not administered due to no 21, 8:00 p.m.: Sodium chloride				
	•	-not administered-high				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		WOOD LANE			
		BIG LAKE	E, MN 55309			
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0 620		21, 8:00 p.m.: <b>M</b> uro 128	0 620			
	ophthalmic solution *October 14, 2021, ophthalmic solution	:00 p.m.: Sodium chloride -declined 4:00 p.m.: Sodium chloride -declined				
	*October 15, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-not administered per RN *October 20, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-declined *October 22, 2021, not on the list *October 30, 2021, 8:00 a.m.: Moxifloxacin ophthalmic solution-unavailable-waiting to receive from pharmacy. *October 30, 2021, 8:00 p.m.: Restasis eyedrops-need refill					
	*November 4-5, 202 solution- (3 missed *November 5-6 202	21: Moxifloxacin ophthalmic				
	indicated eyedrops transplant surgery a control infection, rej The Mayo Clinic we	bsite, www.mayoclinic.org, immediately after cornea and during recovery helped ection, swelling, and pain. bsite indicated ketorolac was a non-steroidal				
	pain, burning, and is and after eye surge ophthalmic solution used to draw water	rug (NSAID) used to treat nflammation of the eye before ries. Sodium chloride and Muro 128 ointment were out of a swollen cornea.				
	antibiotic used to tre Restasis eyedrops inflammation of the ophthalmic solution	eat infections of the eye. were used to prevent cornea. Prenisolone was a corticosteroid used to mation and rejection of the				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/0	) 1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 620	Continued From pa	ge 7	0 620			
	(FM)-D stated R1 h she needed to have corneal transplant she call FM-D stating ey due to DON-B being prescribed eyedrop 2021, she received stating R1 missed to prednisolone ophthowere told it was the stated at that point R1 into FM-C's horn facility could be found documented and keywhen R1 did not received and line when R1 did not received and	FM-D stated on November 6, a phone call from FM-C wo days' worth of almic solution, stating they pharmacy's fault. FM-D R1's family decided to move he until another assisted living nd. FM-D stated she ept track of dates and times beive her medications, M-D provided the document to or).				
	(DON)-B stated she	3:00 p.m., director of nursing was in charge of ordering sulin, and as needed (PRN)				
	not feel safe when setating DON-B alwards she required eye draws transplant rejection her corneal transplant rejection personnel (ULP)-E instead of her night dialed up the insulir	10:00 a.m., R1 stated she did she resided at the facility, ays made excuses. R1 stated ops before and after her surgery to help prevent. R1 stated the night before ant surgery, unlicensed gave her morning insulin pentime insulin. R1 stated she pen and administered some lin before realizing it was the				
		1:00 p.m., unlicensed stated she was distracted				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309			
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0 620	Continued From pa	ge 8	0 620			
	when R1 asked for stated she immedia injected the wrong it told her to monitor if ULP-E stated she a rechecked her bloothe medication error complete an incider had the option of che "unavailable," when unavailable.  The licensee policy Maltreatment-Preve August 1, 2021, indicated staff members on it maltreatment, include exploitation, and ne constituted maltreatment.	her nighttime insulin. ULP-E stely called DON-B after R1 nsulin. ULP-E stated DON-B R1 during the rest of her shift. and ULP-J monitored R1 and d sugars at least once after r. ULP-E stated she did not nt report. ULP-E stated staff narting "declined" or				
0 630 SS=F	for reporting ma  (b) The facility must individual abuse prevulnerable adult. The individual individual including person's susceptibility individual, including person's risk of abuse and statements of the taken to minimize the and other vulnerable abuse prevention person's research abuse.	t develop and implement an evention plan for each ne plan shall contain an w or assessment of the lity to abuse by another other vulnerable adults; the using other vulnerable adults; he specific measures to be ne risk of abuse to that person e adults. For purposes of the lan, abuse includes	0 630			
	TING WITH TROGUNGING	SHE IS HOLHICL AS CVIACHOOD				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/0	; 1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		<b>NOOD LANE</b> E, <b>MN 55309</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 630	licensee failed to ac abuse and implement reduce the risk of a residents (R1, R2, R). This practice results violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential of the residents).  Findings Include:  R1 R1's medical record to the facility on Augincluded legal blinding dystrophy (heredital degeneration, and generation, and generation, and generation, and generation and toileting (pericare), laundry, and housel mobility.  R1's registered nurs September 10, 202 nursing (DON)-B, in self-administer medical self-administer self-administer medical self-administer medical self-administer medical self-administer self-admini	and record review, the Idress all areas of potential ent specific interventions to buse for three of three R3) with records reviewed.  Ed in a level two violation (a tharm a resident's health or otential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all was reviewed. R1 admitted gust 27, 2021. R1's diagnoses ness, Type 1 diabetes, Fuchs' ry eye condition), macular glaucoma.  Atted August 28, 2021, and assistance with personal ally blood glucose checks, assistance, diabetic foot care, a wireless call pendant, keeping. R1 used a walker for see (RN) assessment dated 1, completed by director of adicated R1 was unable to dications safely. R1 had partial threquired staff assistance in	0 630			

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  SES NORWOOD LANE BIG LAKE, MN 55309    Continued From Page 10   DePROVED AND PREFIX   DEPONDED AND PREFIX	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
SUMMARY STATEMENT OF DEFICIENCIES   SIGNARY   STATEMENT OF DEFICIENCIES   PREFIX   (EACH DEFICIENCY MUST SE PRECEDED BY FULL   TAG   PREFIX   (EACH DEFICIENCY MUST SE PRECEDED BY FULL   TAG   PREFIX   TAG   PREFIX			34175	B. WING			
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  RT individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 was susceptible to being abused by another individual with a needed intervention of staff would identify risk factors, assess and monitor yearly with any suspected incident, and educate staff on identifying or treating possible abuse or neglect.  Rt's IAPP lacked evidence R1 was assessed for her susceptibility to being abused by other vulnerable adults, her risk for self-abuse, and statements of specific measures to be taken to minimize her risk of being abused.  R2  R2's medical record was reviewed. R2 admitted to the facility on September 22, 2021. R2's diagnoses included, but were not limited to Type 2 Diabetes, diabetic neuropathy, chronic kidney disease (CKD) Stage 4, chronic obstructive pulmonary disease (CCPD), and chronic heart failure (CHF).  R2's RN assessment dated January 18, 2022, and completed by DON-B, indicated R2 used a walker or cane inside her apartment. R2 was able to safely self-administer topical ointments, creams, transdermal patches, inhalents, subcutaneous injections, and oxygen. Directly below these assessments was a contradicting summary indicating R2 was unable to self-administer medications safely. R2 required diabetic foot care. R2 was short-of-breath and used oxygen. R2 was independent in using her continuous positive airway pressure (CPAE) machine.			655 NORV	VOOD LANE			
R1' individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 was susceptible to being abused by another individual with a needed intervention of staff would identify risk factors, assess and monitor yearly with any suspected incident, and educate staff on identifying or treating possible abuse or neglect.  R1's IAPP lacked evidence R1 was assessed for her susceptibility to being abused by other vulnerable adults, her risk for self-abuse, and statements of specific measures to be taken to minimize her risk of being abused.  R2 R2's medical record was reviewed. R2 admitted to the facility on September 22, 2021. R2's diagnoses included, but were not limited to Type 2 Diabetes, diabetic neuropathy, chronic kidney disease (CKD) Stage 4, chronic obstructive pulmonary disease (COPD), and chronic heart failure (CHF).  R2's RN assessment dated January 18, 2022, and completed by DON-B, indicated R2 used a walker or cane inside her apartment. R2 was able to safely self-administer topical ointments, creams, transdermal patches, inhalents, subcutaneous injections, and oxygen. Directly below these assessments was a contradicting summary indicating R2 was unable to self-administer redications safely. R2 required diabetic foot care. R2 was short-of-breath and used oxygen. R2 was independent in using her continuous positive ainway pressure (CPAP) machine.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
TYZ 3 1/ XI I MAKOM DAHMAIY TO, ZUZZ, IIIMIDAKOM TYZ	0 630	R1' individual abuse November 9, 2021, to being abused by needed intervention factors, assess and suspected incident, identifying or treating.  R1's IAPP lacked enher susceptibility to vulnerable adults, how the vulnerable adults, how the facility on Septimental ending of the facility on Septimental ending of the facility on Septimental ending of the facility on Septimental ending to the facility on Septimental ending of the facility of the facility on Septimental ending of the facil	e prevention plan (IAPP) dated indicated R1 was susceptible another individual with a of staff would identify risk monitor yearly with any and educate staff on g possible abuse or neglect.  vidence R1 was assessed for being abused by other er risk of abusing other er risk for self-abuse, and fic measures to be taken to being abused.  d was reviewed. R2 admitted otember 22, 2021. R2's, but were not limited to Type eneuropathy, chronic kidney ge 4, chronic obstructive (COPD), and chronic heart of the apartment. R2 was able interest topical ointments, all patches, inhalents, tions, and oxygen. Directly sments was a contradicting R2 was unable to lications safely. R2 required R2 was short-of-breath and as independent in using her airway pressure (CPAP)	0 630			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	34175	B. WING		02/0	; 1/2022	
NAME OF PROVIDER OR SUPPLIER  KELLER LAKE COMMONS	655 NORV	DRESS, CITY, S VOOD LANE , MN 55309				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
would identify risk far yearly with any suspitated on identifying of neglect.  R2's IAPP lacked spread to minimize her risk.  R2's service plan daindicated R2 receive cares, two times daineals, medication as a wireless call pendinousekeeping. R2 mobility.  R3 R3's medical record to the facility on Jan comprehensive home receiving assisted li 2021. R3's diagnose limited to Type 2 Diachronic kidney disease fibrillation (Afib), and anticoagulants. R3 and walker for mobil assistance of one use R3's RN assessment completed by DON-assistance with medical self-administer inhal injections, but also it self-administer her in nurse to follow-up (I	eded intervention of staff actors, assess and monitor bected incident, and educate or treating possible abuse or becific measures to be taken of being abused.  ated February 1, 2022, ed assistance with personal ily blood glucose checks, assistance, oxygen saturation, ant, laundry, and used a four-wheeled walker for a was reviewed. R3 admitted huary 25, 2021, under the ne care license, and began ving services on August 1, es included, but were not abetes Mellitus with diabetic ase Stage 4, paroxysmal atrial d long-term use of used a manual wheelchair ility and walked with staff	0 630				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/0	) 1/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
0 630	Continued From pa	ge 12	0 630				
	R3 received assistate behaviors, escorts, positioning, toileting monitoring, twice day thrombo-embolus of monthly RN supervand housekeeping.  R3's IAPP dated Jurequired a gait belt walking. R3 require emergency due to be manual wheelchair, abused with needed risk assessment. Stransfer R3 on her stransfer	leterrent (TED) stockings, ision for TED hose, laundry,  ly 7, 2021, indicated R3 with staff assist of one when d assistance in the event of an being unable to self-propel her R3 was vulnerable to being d interventions of a yearly fall taff were to encouraged to strong side.					
	risk of being abused by another vulnerable adult, her risk of abusing other vulnerable adults, her risk for self-abuse, and statements of specific measures to be taken to minimize her risk of being abused.						
	resident's IAPPs we assessments and u	22, at 2:04 p.m., DON-B stated ere addressed in RN pdated annually or whenever e to their service plans.					
	Prevention Plan, up indicated IAPPs we vulnerable adult. The individualized review person's susceptibilities individual, including (b) the person's risk adults, and; (c) state	titled Individual Abuse dated August 1, 2021, re developed for each le IAPP would contain an or assessment of the lity to abuse by another (a) other vulnerable adults; (b) of abusing other vulnerable ements of the specific (a) to minimize the risk of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		34175	B. WING			) 1/ <b>2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE , MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 630	Continued From pa	ge 13	0 630			
	abuse to that perso including self-abuse	n and other vulnerable adults, e.				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01470 SS=F		ontent of required orientation	01470			
	topics: (1) an overview of t (2) an introduction a policies and proced of assisted living se person; (3) handling of eme emergency services (4) compliance with maltreatment of vul 626.557 to the Minr Center (MAARC); (5) the assisted livin responsibilities rela and protection of th (6) the principles of and service delivery support services pr (7) handling of resid complaints, and wh including information Facility Complaints; (8) consumer advoc Ombudsman for Lo Ombudsman for Me Developmental Disa Ombudsman at the Services, county-m other relevant advoc	and review of the facility's ures related to the provision ervices by the individual staff argencies and use of s; and reporting of the nerable adults under section nesota Adult Abuse Reporting and bill of rights and staff ted to ensuring the exercise ose rights; person-centered planning and how they apply to direct ovided by the staff person; dents' complaints, reporting of ere to report complaints, on on the Office of Health cacy services of the Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or				

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AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	COMPLETED	
			D. MAINIC		С	
		34175	B. WING		02/01/2022	
NAME OF PRO	VIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER LA	KE COMMONS		VOOD LANE , MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETE DATE
01470 Cd	ontinued From pa	ge 14	01470			
se factorise transport	rvices the employ cility's category of In addition to the entation may also rvices to resident sining on hearing bedivision must be sed, may include clude training on the clude training on the challenges it portions at may enhance of the challenges it portions at may enhance of the challenges it portions at may enhance of the color of the co	vee will be providing and the flicensure. It topics in paragraph (a), contain training on providing s with hearing loss. Any loss provided under this high quality and research online training, and must one or more of the following of age-related hearing loss itself, its prevalence, and ses to communication; elated to untreated loss, such as increased tia, falls, hospitalizations,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
71101 1211	OF CONTRECTION	IDENTIFICATION NOTES	A. BUILDING:			
		34175	B. WING		C 02/01/2022	)
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	ETE
01470	Continued From pa	age 15	01470			
	ULP-E's personnel up-to-date annual to *Review of the rights (BOR)  *Principles of personnel up-to-date annual to *Consumer advorman for Low *Review of the services the employ  ULP-F  ULP-F  ULP-F  ULP-F  VARIANTE OF SERVICES  ULP-F's personnel up-to-date annual to *Review of the rights (BOR)  *Principles of personnel up-to-date annual to *Review of the rights (BOR)  *Principles of personnel up-to-date annual to *Review of the rights (BOR)  *Principles of personnel up-to-date annual to *Review of the rights (BOR)	assisted living (AL) bill of erson-centered planning and sidents' complaints, reporting ere to report complaints vocacy services of the Office of ong-Term Care (OOLTC) types of assisted living yee would be providing.  In May 25, 2021 to provide to the licensee's residents.  In the record lacked evidence of raining to include:  I assisted living (AL) bill of erson-centered planning and				
	complaints, and where adverse and the complaints and where adverse and the complaints and where adverse and where adverse adverse and the complaints and where adverse and where adverse and where a complaints are a complaints and where a complaint are a complaint.	sidents' complaints, reporting ere to report complaints vocacy services of the Office of ong-Term Care (OOLTC) types of assisted living yee would be providing				
		n December 22, 2021 to services to the licensee's				

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Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/0	) 1/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KELLER	LAKE COMMONS		WOOD LANE E, MN 55309				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE	
01470	up-to-date annual transport (BOR) *Principles of proservice delivery *Handling of rescomplaints, and what (Consumer add) Ombudsman for Loar (Review of the services the employ)  ULP-H ULP-H was hired or direct care services  ULP-H's personnel up-to-date annual transport (Principles of proservice delivery *Handling of rescomplaints, and what (Consumer add) Ombudsman for Loar (Principles of proservice)  *Review of the services the employ  Request for additional documents was not to the service of th	record lacked evidence of raining to include: assisted living (AL) bill of erson-centered planning and sidents' complaints, reporting ere to report complaints rocacy services of the Office of ong-Term Care (OOLTC) types of assisted living yee would be providing.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.  In April 19, 2021 to provide to the licensee's residents.		DEFICIENCY)			
		titled, Orientation and august 1, 2021, indicated all					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С	
		34175	B. WING		02/0	1/2022
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KELLER	LAKE COMMONS		WOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERTION (	D BE	(X5) COMPLETE DATE
01470	Continued From pa		01470			
	to assisted living factors and regulations before services to resident completed once for not transferrable to	nust complete and orientation cility licensing requirements ore providing assisted living s. Orientation must be each staff person, and was another home care provider.  CORRECT: Twenty-One (21)				
	144G.64 TRAINING REQUIRED	IN DEMENTIA CARE	01530			
	following training re (1) supervisors of d least eight hours of specified under par hours of the employ have at least two hours at least eight hours at least eight hours specified under par hours of the employ initial training is comprovide direct care employee on site weight hours of training dementia care and and assist if issues requirements under meeting the require	irect-care staff must have at initial training on topics agraph (b) within 120 working ment start date, and must ours of training on topics care for each 12 months of				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34175	B. WING	B. WING		) 1/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KELLER	LAKE COMMONS		WOOD LANE E, MN 55309				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
01530	Continued From pa	ge 18	01530				
	by: Based on interview licensee failed to en personnel (ULP-E, required amount of required time frame affect all residents.  This practice results violation that did no safety but had the president's health or widespread scope (or represent a system or has the potential the residents).  The finding include:  ULP-E  ULP-E was hired or direct care services  ULP-F; employee of eight hours of recompleted within 12  ULP-F  ULP-F was hired or direct care services  ULP-F; employee of eight hours of recompleted within 12  ULP-F  ULP-F was hired or direct care services  ULP-F's employee of eight hours of recompleted within 12  ULP-G	n August 10, 2021, to provide to the licensee's residents.  record did not indicated a total quired dementia training was 20 hours of ULP-E's start date.  In May 25, 2021 to provide to the licensee's residents.  record did not indicated a total quired dementia training was 20 hours of ULP-F's start date.					
	ULP-G was hired or	•					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34175	B. WING		02/0	) 1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
KELLER	LAKE COMMONS		VOOD LANE			
			, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01530	Continued From pa	ge 19	01530			
	residents.					
	of eight hours of red	record did not indicated a total quired dementia training was 20 hours of ULP-G's start date.				
	(DON)-B stated UL	3:00 p.m., director of nursing Ps must complete all prior to performing resident				
	Request for addition was not provided.	nal orientation training records				
	updated August 1, 2	titled, Training Records, 2021, indicated the licensee d of staff training and				
	TIME PERIOD TO days.	CORRECT: Twenty-One (21)				
01620 SS=G	144G.70 Subd. 2 (days		01620			
	be conducted no mafter initiation of servessessment and as needed based or resident and cannot from the last date of (d) For residents or services specified in 9, clauses (1) to (5) individualized initial and preferences. The completed within 30	essment and monitoring must ore than 14 calendar days rvices. Ongoing resident monitoring must be conducted n changes in the needs of the texceed 90 calendar days f the assessment. It is not to be a section 144G.08, subdivision the facility shall complete an review of the resident's needs the initial review must be a calendar days of the start of monitoring and review must				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34175				C 2/01/2022
	PROVIDER OR SUPPLIER	655 NOR\	DRESS, CITY, S NOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01620	the needs of the rescalendar days from (e) A facility must in of the availability of long-term care consection 256B.0911, prospective resident facility or the date of resident moves in, which is more facility or the date of resident moves in, which is more facility or the date of resident moves in, which is more facility or the date of residents (R1) with not perform a reassurable facility or a reassurable facility or control, infection proposed personnal insuling to self-administration after here. This practice required control, infection proposed for a violation that harmen of including serious or a violation that harmen of including serious or a violation that has serious injury, impairs a limited number of real limited number of	eeded based on changes in sident and cannot exceed 90 the date of the last review. If form the prospective resident and contact information for sultation services under prior to the date on which a sit executes a contract with a sin which a prospective whichever is earlier.  In the is not met as evidenced and record review, the insure a registered nurse (RN) is ments for one of three records reviewed. The RN did sessment for R1 after sel (ULP) gave her the wrong inster. In addition, the RN did ter her corneal transplant and the seye drops pertinent for pain evention and rejection				
	R1 R1's medical record	d was reviewed. R1 admitted				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		E SURVEY PLETED
		34175	B. WING			C <b>01/2022</b>
	PROVIDER OR SUPPLIER	655 NOR	DRESS, CITY, S' WOOD LANE E, MN 55309	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
01620	diagnoses included blindness, Fuchs' d condition), macular R1's service plan daindicated R1 receive assistance.  R1's RN assessme indicated R1 was unlabels due to poor vocorrect number of inby listening to the coverified and superviblindness.  R1's progress note 12:13 p.m., indicated after her corneal transfer her corneal transfer staff provided administer and after surgery.  R1's medical administer and after surgery.  R1's medical administer and after surgery.  R1's medical administer three a.m., 11:30 a.m., 4: Basaglar (long-actin long-actin	August 27, 2021. R1's Type 1 diabetes, legal ystrophy (hereditary eye degeneration, and glaucoma.  ated August 28, 2021, ed assistance with medication  nt dated September 10, 2021, nable to read medication vision. R1 was able to dial the nsulin units on her insulin pens licks on the pens which staff ision. R1 had partial or total  dated October 13, 2021, at ed R1 returned to the facility				
	dated October and	nistration records (MARs) November 2021, indicated R1 following eye drops and				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			COMPLETED	
				С		
34175		B. WING		02/01/2022		
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, S	TATE, ZIP CODE			
KELLER LAKE COMMONS	655 NORWO BIG LAKE, I					
(X4) ID SUMMARY STATEMENT OF DEI PREFIX (EACH DEFICIENCY MUST BE PREC TAG REGULATORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	ACTION SHOULD BE COMP TO THE APPROPRIATE DATE		
insulin: sodium chloride ophthalinstill one drop into right eye fou (QID). Must wait five minutes be moxifloxacin ophthalmic solution drop into right eye two times per prednisolone acetate ophthalmic instill one drop into right eye QID minutes between different drops instill one drop BID in post-operweek, then one drop daily for see begin drops three days before soctober 13, 2021; Muro 128 5% apply 1/2 inch ribbon to right eye administered after last eye drop administer one drop into right eye administer one drop into right eye administer one drop into right eye action of the per day (TID), staff to verify dos (long-acting insulin) 30 Units, reself-administer once daily (8:00 verify dose.  R1's September, October, and Medication Administration Summidid not receive her eye drops or dates:  *September 1-16, 2021, 8:00 p.m. ophthalmic solution-not adminis supply  *September 30, 2021, 8:00 p.m. ophthalmic solution-not adminis glucose  *September 30, 2021, 8:00 p.m. so ophthalmic solution-declined  *October 6, 2021, 8:00 p.m.: So ophthalmic solution-declined  *October 14, 2021, 4:00 p.m.: So ophthalmic solution-not adminis solution-declined  *October 20, 2021, 4:00 p.m.: So ophthalmic solution-not adminis	mic solution, 5%, r times per day etween drops; n, 0.5%, instill one day (BID); c solution 1%, D. Must wait five s; ketorolac 0.5%; ative eye for one even more weeks, urgery on eye ointment, e daily, must be; Restasis, re daily novalog inister three times e; basaglar sident to p.m.), staff to  November 2021 mary, indicated R1 in the following m.: Ketorolac tered due to no  Sodium chloride tered-high  Muro 128  dium chloride odium chloride odium chloride odium chloride	01620				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34175	B. WING		1	C <b>)1/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE ., MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01620	ophthalmic solution from pharmacy. *October 30, 2021, eyedrops-need refil *November 4-5, 202 solution- (3 missed *November 5-6 202 ophthalmic solution  The Mayo Clinic we indicated eyedrops transplant surgery a control infection, refine Mayo Clinic we ophthalmic solution anti-inflammatory dipain, burning, and if and after eye surge ophthalmic solution used to draw water Moxifloxacin ophthalmic solution used to draw water Moxifloxacin ophthalmic solution used to the Restasis eyedrops inflammation of the ophthalmic solution help prevent inflammation of the o	redeclined not on the list 8:00 a.m.: Moxifloxacin -unavailable-waiting to receive 8:00 p.m.: Restasis 21: Moxifloxacin ophthalmic doses)-no supply 1: Prednisolone acetate (5 missed doses)-no supply 1: Prednisolone acetate (5 missed doses)-no supply 1: bsite, www.mayoclinic.org, immediately after cornea and during recovery helped fection, swelling, and pain. bsite indicated ketorolac was a non-steroidal rug (NSAID) used to treat inflammation of the eye before ries. Sodium chloride and Muro 128 ointment were out of a swollen cornea. almic solution was an eye eat infections of the eye. were used to prevent cornea. Prenisolone was a corticosteroid used to mation and rejection of the a.  10:00 a.m., R1 stated on at 8:00 p.m., she are wrong insulin after ULP-E ng insulin pen. R1 stated she 2 Units of Novolog before she	01620			

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Minnesota Department of Health

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
		34175	B. WING		02/0	) 1/2022
		04170			1 02/0	11/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE :, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01620	Continued From pa	ge 24	01620			
	nighttime insulin. Ul called DON-B after ULP-E stated DON-during the rest of he ULP-J monitored R sugars at least once ULP-E stated she dimedication error reports of the performed character of the performance of the	2, at 2:04 p.m., DON-B stated nge in condition assessments returned from the hospital. she did not perform				
	and Monitoring, upon indicated the RN colors based on the change and would not excelled date of the last asset	titled Assessments, Reviews, dated August 1, 2021, and needs of the resident ed 90 calendar days from the essment.  CORRECT: Seven (7) days.				
	144G.70 Subd. 4 (a implementation and	,	01640			
	that services are first facility shall finalize (b) The service plan include a signature facility and by the reaspeament on the service plan must be resident reaspeases.	calendar days after the date st provided, an assisted living a current written service plan. and any revisions must or other authentication by the esident documenting ervices to be provided. The e revised, if needed, based on ent under subdivision 2. The information to the resident				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE COMF	SURVEY
	34175	B. WING		C <b>)1/2022</b>
NAME OF PROVIDER OR SUPPL	ER STREET AD	DDRESS, CITY, STATE, ZIP CODE		
KELLER LAKE COMMONS		WOOD LANE E, MN 55309		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETE DATE
and how to cont Long-Term Care (c) The facility mervices require (d) The service must be entered including notice when applicable (e) Staff providing the current writter. This MN Requires by:  Based on intervilicensee failed to provided and imcurrent service provided and imcurre	o the facility's fee for services act the Office of Ombudsman for a cust implement and provide all d by the current service plan. In olan and the revised service plan into the resident record, of a change in a resident's fees a g services must be informed of the service plan.  The ment is not met as evidenced as directed in the plans for two of three residents cords reviewed.  The potential to have harmed a cor safety, but was not likely to jury, impairment, or death), and pattern scope (when more than a cor residents are affected, more imber of staff are involved, or the curred repeatedly; but is not asive).			

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Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	COMP	SURVEY LETED
		34175	B. WING		02/0	; 1/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	<u>i OZIO</u>	1/2022
KELLER	LAKE COMMONS		VOOD LANE , MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
01640	Continued From pa	ge 26	01640			
	indicated R1 received cares, four times da meals, medication a	ated August 28, 2021, ed assistance with personal ally blood glucose checks, assistance, nail care as eting (pericare), a call pendant, keeping.				
	indicated R1 require and stand-by assist	nt dated September 10, 2021, ed supervision with bathing, ance with mobility. R1 dly diabetic foot soaks with				
	2021-October 31, 2 received stand-by a	y record dated August 28, 021, lacked evidence R1 ssistance with mobility, twice soaks, or PRN diabetic nail				
	to the licensee on S diagnoses included 2 Diabetes, diabetic disease (CKD) Stag	was reviewed. R2 admitted september 22, 2021. R2's but were not limited to Type neuropathy, chronic kidney ge 4, chronic obstructive (COPD), and chronic heart				
		nt dated January 18, 2022, OON-B, indicated R2 required				
	indicated R2 receive cares, two times da	ated February 1, 2022, ed assistance with personal ily blood glucose checks, assistance, oxygen saturation, ant, laundry, and				

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEPICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		l ` ′	(X3) DATE SURVEY COMPLETED	
		34175	B. WING		I	C <b>01/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
KELLER	LAKE COMMONS		WOOD LANE E, MN 55309				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
01640	Continued From pa	ge 27	01640				
	R2's service plan fa diabetic foot care.	ailed to include a service for					
	2021-February 1, 2	y record dated October 1, 022, lacked documentation R2 services that were to be vice plan.					
	to the licensee on J comprehensive hor receiving assisted li 2021. R3's diagnos limited to Type 2 Dichronic kidney dise fibrillation (Afib), an anticoagulants (Couwheelchair and wall	d was reviewed. R3 admitted anuary 25, 2021, under the me care license, and began iving services on August 1, es included, but were not abetes Mellitus with diabetic ase Stage 4, paroxysmal atrial d long-term use of umadin). R3 used a manual ker for mobility and walked e of one using a gait belt.					
	completed by DON- nurse to follow-up of	nt dated July 7, 2021, and -B, indicated R3 required a on new orders as needed, and medical appointments.					
	R3 received assistated monitoring, twice date thrombo-embolus date.	ated August 1, 2021, indicated ance twice daily blood glucose aily assistance with leterrent (TED) stockings, and nurse (RN) supervision for the					
	•	id not include R3's nursing of R3's International NR).					
	10:27 a.m., and wri	dated August 28, 2021, at ten by director of nursing she obtained R3's INR					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		34175	B. WING		02/0	) 1/2022
KELLER LAKE COMMONS 655 NORV		DRESS, CITY, S VOOD LANE MN 55309				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01640	INR results.  On April 7, 2022, at nursing staff obtain machine that R3 had provider would adjudent INR results.  On February 1, 202 service plans were there was a change DON-B stated her justice plans were DON-B stated services staff provider on April 1, 2022, at scheduled services October. R2 stated was admitted on Selfonthing was happed 20, 2021, she and believed assisted like DON-B to discuss for the received. R2 stated services after her machine between the services that we designated represente services that we resident. Service plassed on resident	ge 28 lated R3's provider with her  11:04 a.m., DON-B stated ed R3's INR from an INR ad. DON-B stated R3's lest R3's Coumadin based upon  12, at 2:00 p.m., DON-B stated revised annually or when in the resident's condition. To duties included ensuring up-to-date and accurate. Ice plans described all the ded for the residents.  11:10 a.m., R2 stated her did not start until the end of she was confused after she extember 22, 2021, stating, ening." R2 stated on October her family had a meeting with wing director (LALD)-I and her services she never she started receiving her neeting with LALD-I and  titled, Service Plan, updated icated service plans were en a resident or resident's notative and the facility about build be provided to the ans were revised, if needed, eassessments and monitorin.  CORRECT: Seven (7) days.	01640			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/0	1/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KELLER	LAKE COMMONS		NOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01730	Continued From pa	ge 29	01730			
01730 SS=I		dividualized medication	01730			
	management service must prepare and it written statement of services that will be facility must develop individualized mediceach resident base assessment that m (1) a statement design management service (2) a description of on the resident's near diversion, and considerections; (3) documentation of relating to the admit (4) identification of monitoring medicate medication refills and (5) identification of tasks that may be of personnel; (6) procedures for some appropriate when a problem and management service (7) any resident-specifications that all as prescribed, and to prevent possible reactions. (b) The medication	ust contain the following: cribing the medication ces that will be provided; storage of medications based eds and preferences, risk of istent with the manufacturer's of specific resident instructions nistration of medications; persons responsible for ion supplies and ensuring that re ordered on a timely basis; medication management delegated to unlicensed staff notifying a registered e licensed health professional ses with medication				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34175	B. WING			C <b>01/2022</b>
	PROVIDER OR SUPPLIER	655 NORV	DRESS, CITY, S VOOD LANE E, MN 55309	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01730	when a licensed nu professional, or aut medication manage. This MN Requirements: Based on interview licensee failed to expression or a timely medication manage residents (R1, R2, If this practice results violation that has provided in a timely medication manage residents (R1, R2, If this practice results violation that has provided at a widesprare pervasive or rephase affected or has portion or all of the findings Include:  R1 R1's medical record to the licensee on Adiagnoses included blindness, Type 1 de (hereditary eye con and glaucoma.  R1's service plan data.	nciliation must be completed rse, licensed health horized prescriber is providing ement.  ent is not met as evidenced and record review, the nsure medication refills were basis as required in the ement plan for three of three R3) with records reviewed.  ed in a level three violation (and a resident's health or safety, as injury, impairment, or death, as the potential to lead to irment, or death) and was lead scope (when problems oresent a systemic failure that potential to affect a large	01730			
		se (RN) assessment dated 1, indicated R1 was able to				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	L COMPLETED	
		34175	B. WING	_		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
KELLER	LAKE COMMONS		WOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECT)	ULD BE	(X5) COMPLETE DATE
01730	Continued From pa	ge 31	01730			
		nber of insulin units on her ening to the clicks on the pensend supervised.				
	September 16, 202	itial home visit dated  1, indicated staff were to  11 with her eye drop				
	R1's individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 required assistance with medication administration due to partial or total blindness.					
	dated August 27, 20 indicated R1 was promedications: a thyrother two different steroid different antibiotic to three different blood for constipation, two (short-acting and lowedication, vitamin and one eye ointmeters).	nistration records (MARs) 221 to November 6, 2021, rescribed the following oid pill, allergy tablet, aspirin, d creams for her skin, two ablets, a stool softener tablet, d pressure pills, fiber powder o different types of insulin ong-acting), cholesterol s, and six different eye drops ent prescribed before and after ant surgery to prevent rejection cornea.				
	was not administered eye drops, and eye August 2021: 5 dos insulin, 3 doses of eigenment. September 2021: 2 doses of eye medic ointment. October 2021: 12 d	ober 2021 MARs indicated R1 ed the following medications, ointment due to no supply: ses of medications, 1 dose of eye drops, and 1 dose of eye 0 doses of medications, 12 eations, and 1 dose of eye oses of medications, 7 doses dose of eye ointment.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/0	) 1/2022
	NAME OF PROVIDER OR SUPPLIER  KELLER LAKE COMMONS  STREET A  655 NOF BIG LAKE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01730	30 Continued From page 32		01730			
	to the licensee on Sidiagnoses included 2 Diabetes, diabetic disease (CKD) Stag pulmonary disease failure (CHF).  R2's RN assessme and completed by Disto safely self-administer medications transderms subcutaneous inject below these assess summary indicating self-administer medicated R2 required assistance R2's service plan daindicated R2 received R2's MARs dated Condicated R2 was promedications: a thyrodifferent types of an two different types of an two di	nuary 18, 2022, indicated R2 in medication administration.  ated January 18, 2022, ed medication assistance.  October 2021-January 2022, rescribed the following oid pill, gout tablet, aspirin, two atidepressants, a water pill, of insulin (fast-acting and ), vitamins, two different types ablets, cholesterol tablet, and tomach acid.  ed R2 was not administered ations due to no supply: se of medication.				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	l ` ′	(X3) DATE SURVEY COMPLETED	
		34175	B. WING			C <b>01/2022</b>
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
KELLEF	R LAKE COMMONS		<b>WOOD LANE E, MN 55309</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01730	to the licensee on F diagnoses included Diabetes Mellitus Tr CHF, and hyperlipid R3's RN assessme and completed by E complicated medical assistance with meadministration.  R3's service plan dindicated R3 receive management, medicated R3 was perfect medications: a lotion insulin, an oral diabestool softener, narrodifferent types of arblood pressure tablesteroid creams, oral with water, oral stemanticoagulant (Court R3's record indicated R3 was perfect types of arblood pressure tablesteroid creams, oral with water, oral stemanticoagulant (Court R3's record indicated the following medical August 2021: 9 doses of insulin (not September 2021: 27 doses of other meand 1 dose of topic R3's nurse progress at 3:13 p.m., indicated R3's nurse progress at 3:13 p.m.	d was reviewed. R3 admitted February 18, 2020. R3's I, but were not limited to to the sype 2, CKD Stage 4 (severe), demia (high cholesterol).  Int dated September 30, 2021, DON-B, indicated R3 had a lation regimen and required dication management and lated February 1, 2022, ed assistance with medication ication set-up, and medication ication set-up, and medication in used for rash, a long-acting letic tablet, anti-fungal powder, lotic pain pill, vitamins, two intibiotics, a water pill, one et, two different types of all potassium packets mixed roid tablet, and an imadin).  Ed R3 was not administered lations due to no supply: less of Coumadin medication, 2 oneedle supply). In doses Coumadin medication, 2 oneedle supply). In doses Coumadin medication, 2 oneedle supply).				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ´	E CONSTRUCTION	COMPLETED	
	34175	B. WING		02/0	) 1/ <b>2022</b>
NAME OF PROVIDER OR SUPPLIER KELLER LAKE COMMONS	655 NOR\	DRESS, CITY, S' NOOD LANE  , MN 55309	TATE, ZIP CODE		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
every Monday and Nurses were to reconstruction of 2021, at 4:30 p.m., administered three milligrams (mg). The was due to an omistevening shift. The redocumented as no and update on-call R3's prescriber was The report was reprodirector of nursing at 2:29 p.m.  R3's nurse progress at 6:14 p.m., indicator or a daily. Nursione week.  R3's nurse progress 2021, at 12:40 p.m. Nurses were to adridaily recheck her If On April 4, 2022, at most medications with the same day once pharmacy.  On April 5, 2021, at moved into the facility and the five to seven day once pharmacy.	bumadin order, giving R3 1 mg 2 mg the rest of the week. The check R3's INR in one week. The report dated August 6-8, indicated R3 was not days' of Coumadin, 25 he report indicated the error ssion that occurred during an report indicated, "staff supply, did not follow protocol nurse." The report indicated is notified. 911 was not called. Forted and reviewed by the (DON)-B on August 18, 2021, ated R3's INR was 1.3. A new led increasing R3's Coumadin les were to recheck R3's INR in in the since should be something the since of the coumadin les note dated September 13,, indicated R3's INR was 1.3. Indicated R3				

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STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34175	B. WING		1	C <b>01/2022</b>
NAME OF PROVIDER	OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
KELLER LAKE C	OMMONS		VOOD LANE E, MN 55309			
	CH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
prescriafter he rejection family ran out missed transple eyesig.  On Aproperson document they ran were sometime to the resider of the resider of the resider of the resider medical document t	bed several er surgery to on. R1 stated moved her of her eye of several dos ant surgery ht was, "very ht was, "very ht was, "very ht either ur n out of medication at stated ULP message from the medication labels used for resident rains at the phase at the phase medication are medication for the medication or the phase the phase medication are medication to the phase the phase every the ents ev	221. R1 stated she was different eye drops before and prevent corneal transplant don November 6, 2021, her out of the facility after the facility drops for two days, stating she ses. R1 stated her corneal did not go well, stating her opoor."  1 1:00 p.m., unlicensed stated ULP had the option to havailable or declined when dications. ULP-E stated ULP alert the nurses whenever ons were running low, stated, the nurses would not nout of their medications. could alert nurses by sending om their work phone, or peel pel and apply it to a note pad de-ordering medications.  1 12:00 p.m., ULP-G stated armacy took a long time to ons.  22, the director of nursing e was responsible for ensuring ce plans were up-to-date and tated the resident's service erything staff did for the re they provide, and the eed. DON-B stated, "it ing."  1 titled Medication Management, updated August 1, 2021,				
		see would prepare and include rvice plan a written statement				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		34175	B. WING			) 1/ <b>2022</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS	655 NOR\				
			E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
01730	Continued From page 36		01730			
	of the medication management services that would be provided to the resident.					
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01750 SS=I			01750			
	When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:  (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;  (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and  (3) communicated with the unlicensed personnel about the individual needs of the resident.					
	by: Based on interview licensee failed to er	,				
	violation that harmed not including serious or a violation that has serious injury, impa- issued at a widesprare pervasive or rep	ed in a level three violation (a ed a resident's health or safety, s injury, impairment, or death, as the potential to lead to irment, or death) and was ead scope (when problems present a systemic failure that potential to affect a large residents).				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34175	B. WING		02/0	; 1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE 5, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01750	Continued From pa	ge 37	01750			
	The findings include	ed:				
	ULP-A ULP-A was hired on July 9, 2020 to provide direct care services to the licensee's residents.  ULP-E ULP-E was hired on August 10, 2021 to provide direct care services to the licensee's residents.  ULP-F ULP-F was hired on May 25, 2021 to provide direct care services to the licensee's residents.  ULP-G ULP-G was hired on December 22, 2021 to provide direct care services to the licensee's residents.					
		June 7, 2021 to provide to the licensee's residents.				
	August 6, 2021 and medication errors work personnel (ULP).	cords indicated between January 23, 2022, 64 Vere made by unlicensed Out of the 64 medication errors, had several medication				
	2022-13 medication *ULP-E: December 2021-2 medication *ULP-F; August 16, medication errors. *ULP-G; December medication errors.	7, 2021-December 16, errors 2021-January 16, 2022-19 28, 2021-January 16, 2022-3 23, 2021-December 30,				

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	NT OF DEFICIENCIES NOF CORRECTION	I DENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/	C <b>01/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
KELLER	R LAKE COMMONS		<b>E, MN 55309</b>				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCE)	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
01750	Continued From pa	ge 38	01750				
	employee records I	P-F, ULP-G, and ULP-J's acked evidence the ULP petency in medication					
	Review of ULP-F's employee record dated September 21, 2021, indicated ULP-F was disciplined due to continued medication errors, giving incorrect medication doses, and documenting "no supply" when supply was in cabinet. ULP-F was assigned to complete all online training modules, and three medication administration observations with a nurse by September 25, 2021.						
	ULP-F completed had medication administrated and February 6, 20, indicated ULP-F ne	training record, indicated er online retraining for stration on December 20, 2021 22. ULP-F's employee records ever completed retraining on stration competencies.					
	indicated ULP-F ha	medication error reports d an additional 13 medication ember 25, 2021 and January					
	majority of medicat fill and delivered au pharmacy. DON-B ordering eye drops, creams, insulin, and pain medications. Edelivered medication stated ULP who had medication errors we required to do retrain	3:00 p.m., DON-B stated ions were ordered on a cycle tomatically from the stated she was in charge of ointments, Coumadin, steroid as needed (PRN) narcotic ON-B stated pharmacy ons the same day. DON-B d more than two or three within a one month period were ining on medication N-B stated retraining included					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED		
		34175	B. WING		C 02/01/2022	
		34173	<u> </u>		0210	1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01750	Continued From pa	ge 39	01750			
	both online and competency training on medication administration.					
	DON-B was unable to explain the 64 medication error reports, stating, "I've been working with them consistently."  Review of ULP-A, ULP-G, and ULP-J's employee records, indicated they were not retrained on medication administration.  On April 4, 2022, at 3:00 p.m., DON-B stated ULP who had more than two or three medication errors within a one month period were required to do retraining on medication administration.  DON-B stated retraining included both online and competency training on medication administration. DON-B was unable to explain the 64 medication error reports, stating, "I've been working with them consistently."					
	dated August 1, 202 would receive quality who were educated of assisted living se	titled Staff Competency, 21, indicated all residents by service delivered by staff and competent in the delivery ervices. The registered nurse ble for the overall competency				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01760 SS=I	144G.71 Subd. 8 Deadministration of mo		01760			
	living facility staff m resident's record. T include the signature	Iministered by the assisted ust be documented in the he documentation must e and title of the person who edication. The documentation				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34175	B. WING		02/0	) 1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
KELLER	LAKE COMMONS		<b>WOOD LANE</b> E, <b>MN</b> 55309			
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD			LD BE	(X5) COMPLETE DATE	
01760	and time administer administration. The reason why medical completed as press follow-up procedure the resident's needs administered as pressive with the resident's r	edication name, dosage, date red, and method and route of staff must document the tion administration was not cribed and document any es that were provided to meet is when medication was not escribed and in compliance medication management plan.  The sure each medication assisted living facility was record and when not escribed, documenting that why, and follow-up rovided to meet the resident's have residents (R1, R2, R3) ed.  The din a level three violation (and a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death), and was ead scope (when problems oresent a systemic failure that potential to affect a large	01760			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34175	B. WING		1	) 1/ <b>2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01760	Continued From pa	ge 41	01760			
	and glaucoma.					
	-	ated August 28, 2021, ed medication assistance four				
	September 10, 202 the correct number pens by listening to staff verified. R1's a	se (RN) assessment dated 1, indicated R1 wa able to dial of insulin units on her insulin the clicks on the pens which assessment indicated R1 was nister medication safely.				
	R1's prescriber's initial home visit dated September 16, 2021, indicated R1 was prescribed the following eye drops: moxifloxacin 0.5% eye drops, one drop into right eye (OD) four times daily (QID); prednisolone 1%-gatifloxacin 0.5%-bromfenac 0.078% eye drops, one drop into OD QID; ketoroloca 0.5% eye drop, one drop into both eyes every night at bedtime (QHS); Systane 0.4%-0.3%, instill one drop into both eyes QHS.					
	October 4, 2021, in her eye medications looked forward to he but was not sure sh	rescriber home visit dated dicated R1 had no changes to s. R1 told her prescriber she er corneal transplant surgery se could trust staff to instill the r administer the drops at the				
	November 9, 2021,	e prevention plan (IAPP) dated indicated R1 needed dication administration due to ness.				
	2021, included, but	ers dated, August-October were not limited to, a lood pressure tablets, a				

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Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
						5
		34175	B. WING		02/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		<b>NOOD LANE</b> E, <b>MN</b> 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	drops, eye drop oin vitamins, allergy tak long-acting insulin.  R1's August-Novem was not administere ointment on the followate and the fo	I softener, six different eye tment, antibiotic tablets, olets, and rapid and ober 2021 MARs indicated R1 and her eye drops and eye owing dates due to no supply:  1 8:00 p.m. 1 at 8:00 p.m. 2021 at8:00 p.m. 21 at 8:00 p.m.	01760	DEFICIENCY		
	p.m., 8:00 p.m. November 6, 2021 p.m.	at 7:00 a.m., 11:00 a.m., 5:00 at 7:00 a.m., 11:00 a.m., 4:00				
	· ·	gust -November 2021 MARs ot adminstered the following				

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AND DIAN OF CORRECTION INTERCATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34175	B. WING		02/01/2022	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02.0	
KELLER	LAKE COMMONS		VOOD LANE , MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
01760	*August 29, 2021-8 tablet *August 31, 2021-8 long-acting insulin ( *September 9-14, 1 2021-8:00 p.m.: Ste *September 5-8, 20 cholesterol tablets *September 6, 202 *October 1-3, 2021 Steroid cream *October 9-10, 202 *October 28, 2021- R1's MARs lacked any follow-up proceafter they failed to a prescribed by her prescri	no supply:  :00 a.m.: Cholesterol tablet :00 p.m.: Blood pressure :00 p.m.: Stool softener, Lantus), and steroid cream 6, 20, 23, 25,27-29, eroid cream :21-8:00 a.m.: Allergy and 1-8:00 p.m.: Antibiotic tablet -8:00 a.m. and 8:00 p.m.: 1-8:00 a.m.: Stool softener 8:00 a.m.: Allergy tablet evidence the facility performed edures to meet R1's needs administer R1's medications as rovider.  d was reviewed. R2 was lity on September 22, 2021. uded, but were not limited to abetic neuropathy, chronic any disease (COPD), and a (CHF).  nt dated January 18, 2022, 200N-B, indicated R2 was able ister topical ointments, all patches, inhalants,	01760	DEFICIENCY)		
	subcutaneous injec	tions, and oxygen (02). e assessments was a R2 was unable to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>l</b> ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D WING		С	
		34175	B. WING		02/0	1/2022
NAME OF I	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01760	R2's service plan daindicated R2 received R2's prescriber order administer Regular two times per day (I and Novolin 70/30 (at bedtime (HS) (10) R2's October 2021 14, 2021, at 10:14 pher intermediate-action on November 9, 15 staff never docume intermediate-acting R2's December 10, 2021 administered her and documenting "no sur R2's MARs lacked experiences."	nuary 18, 2022, indicated R2 in medication administration.  ated January 18, 2022, ed medication assistance.  ers indicated staff were to insulin (short-acting), 40 Units BID) (11:00 a.m., 6:00 p.m.), intermediate-acting), 20 Units 0:30 p.m.) to R2.  MAR indicated on November o.m., R1 was not administered ting insulin due to no needles. 5, and 23, 2021, at 10:30 p.m., anted R1 was administered her insulin.  21 MAR indicated on I, at 11:00 a.m., R2 was not attidepressants due to staff	01760			
	after they failed to a prescribed by her p	administer medications as rovider.				
	admitted to the facil diagnoses included Diabetes Mellitus Ty	d was reviewed. R3 was lity on February 18, 2020. R3's , but were not limited to ype 2, CKD Stage 4 (severe), demia (high cholesterol).				
	R3's IAPP dated Au required assistance administration.	gust 2, 2021, indicated R3 with medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> ` ′	E CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		34175	B. WING		1	C 01/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02.0	
KELLER	LAKE COMMONS		WOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	and completed by E complicated medical assistance with medical administration.  R3's service plan daindicated R3 receive management, medical assistance.  R3's August and Service and Service plan daindicated R3 receive management, medical assistance.	nt dated September 30, 2021, 200N-B, indicated R3 had a ation regimen and required dication management and ated February 1, 2022, ed assistance with medication cation set-up, and medication eptember 2021 MARs of administered Coumadin on due to no supply:				
	*August 6-8, 2021-4 *August 13-15, 202 *August 18, 2021-4 *August 27-28, 202 *September 10, 202 *September 23, 202	1-4:30 p.m.: :30 p.m. 1-4:30 p.m. 21-4:30 p.m.				
	2021, at 4:30 p.m., administered her Color by mouth (PO). The due to an "omission evening shift. The redocumented as no and update on-call R3's prescriber was The report was report was report of nursing (at 2:29 p.m.	indicated R3 was not oumadin, 25 milligrams (mg) report indicated the error was all that occurred during an eport indicated, "staff supply, did not follow protocol nurse." The report indicated in notified. 911 was not called. orted and reviewed by the DON)-B on August 18, 2021, ated R3's international IR) was 1.3.				
	· ·	ed R3's INR therapeutic range				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34175	B. WING		1	C <b>)1/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE			
	211111111111111111111111111111111111111		i, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01760	Continued From page 46		01760			
	was 2.0-3.0.					
	copyrighted 1998-2 be taken exactly as	ebsite, www.mayoclinic.org, 022, indicated Coumadin must directed to work safely and oo little of Coumadin may not				
	In addition, R3's MAR indicated R3 was not adminsitered the following medications due to no supply:					
	insulin (Lantus-no n *September 9-13, 2 *September 9, 2027 *September 23, 202	21-8:00 a.m.: Long-acting needles) 2021-4:30 p.m.: potassium 1-4:30 p.m.: antibiotic 21-4:30 p.m.: antibiotic. 21-8:00 a.m.: steroid cream				
	any follow-up proce	evidence the facility performed edures to meet R3's needs administer medications as rovider.				
	nursing (DON)-B st work phone text me medication reorder	2, at 2:00 p.m. director of ated staff updated her through essage or through a form. DON-B stated forms were checked daily.				
	majority of medication fill and delivered au pharmacy. DON-B ordering eye drops, creams, insulin, and pain medications. Explain medications.					
	On April 4, 2022, at	9:00 a.m., family member				

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AND DIAN OF CORRECTION INTERCATION NUMBER:		<b>l</b> ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		34175	B. WING			C 02/01/2022	
NAME OF	PROVIDER OR SUPPLIER		·	STATE, ZIP CODE	1 OZIO	IIZUZZ	
KELLER	LAKE COMMONS		VOOD LANE 5, MN 55309				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE	
01760	been a Type 1 diab medication regimer after the resident market facility changed R1 retractable, which has stated staff did not end, and R1 ended FM-C stated R1 call the insulin gong into blood sugar shot up deciliter (mg/dL).  On April 4, 2022, at kept a log with date when R1 was not a and other medication.  On April 5, 2022, at moved into the facilitation assistance with her regimen. R1 stated different eye drops after her corneal transcription of the transcription of the transcription of the transcription. R1 stated different eye drops after her corneal transcription of the transcription of the transcription. R1 stated self-administer. R1 the insulin after she insulin, but stated several Units of insuling the prevent her blood several Units of insuling the prevent her blood several Units of the out of the out of her eye drops.	vs mentally intact and had etic for years and knew her in well. FM-C stated shortly loved into the facility, the is insulin needles to lead a cap at the end. FM-C etell R1 there was a cap at the lup not getting her insulin. Iteld her stating she never felt of her. FM-C after that, R1's of to almost 500 milligrams per insulin, eye, ons.  11:00 a.m., FM-D stated she is and times, documenting dministered her insulin, eye, ons.  10:00 a.m., R1 stated she lity because she required daily complicated eye medication she was prescribed several and eye ointment before and ansplant surgery to prevent splanted cornea. R1 stated on the night before her eye we her the wrong insulin to stated she stopped injecting erealized it was the wrong he still ended up injecting ulin. R1 stated she was up ating carbohydrates in order to ugar levels from dropping too lovember 6, 2021, her family he facility after the facility ran is for two days, stating she es. R1 stated her corneal did not go well, stating her	01760				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b> </b> ` ′	E CONSTRUCTION	COMPLETED	
		34175	B. WING		02/0	
		34173			1 02/0	1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	KELLER LAKE COMMONS  BIG LA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
01760	Continued From pa	ge 48	01760			
	had the option to do declined when they ULP-E stated on Oddistracted when R1 insulin. ULP-E state DON-B after R1 injected DON-B told it rest of her shift. UL monitored R1 and releast once after the	1:00 p.m., ULP-E stated ULP ocument unavailable or ran out of medications. Stober 12, 2021, she was asked for her nighttime ed she immediately called ected the wrong insulin. ULP-E ner to monitor R1 during the P-E stated she and ULP-J echecked her blood sugars at medication error. ULP-E complete an incident or port.				
	expected her medicatime and would work ULP-F stated R1 countries of her eye drops for the eye drops she was respected to the facility ran out the next dose was resulted. "it was resulted to the stated of the resulted of th	12:00 p.m., ULP-F stated R1 cations to be administered on ry if she did not get them. Implained if the facility was out "a while," stating, "she knew was supposed to get for her stated R1 became unhappy of one of her eye drops and missed because of no supply. It all of her eye drops that he time, but I'm not sure."				
	Supplies-Reorderin indicated facility nur	titled, Medication and g, updated August 1, 2021, rsing staff would ensure ons and supplies were ordered eded.				
	TIME PERIOD TO	CORRECT: Seven (7) days.				
01940 SS=F		dividualized treatment or n	01940			
		eceiving management of ed treatments or therapy				

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Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPLETED	
					С	
		34175	B. WING		02/01/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE 5, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 49	01940			
	services, the assiste and include in the sistatement of the treatment will be provided must also develop a individualized treatment record contain at least the (1) a statement of the provided; (2) documentation of relating to the treatment administration; (3) identification of will be delegated to (4) procedures for mappropriate licenses problem arises with services; and (5) any resident-sped documentation of the received, verification therapy was administration of the received, verification of the received, verification of the received of the r	ed living facility must prepare ervice plan a written eatment or therapy services to the resident. The facility and maintain a current nent and therapy of for each resident which must following: ne type of services that will be of specific resident instructions				
	violation that did no	t harm a resident's health or otential to have harmed a				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	` ′	(X3) DATE SURVEY COMPLETED		
		34175	B. WING		02/01/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECT TO THE APPROVED	ULD BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 50	01940			
	widespread scope ( or represent a syste	safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	R1 R1's medical record was reviewed. R1 admitted to the licensee on August 27, 2021. R1's diagnoses included, but were not limited to, legal blindness, Type 1 diabetes, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma.					
	indicated R1 receiv	ated August 28, 2021, ed assistance with four times checks and as needed (PRN) om licensed staff.				
	January 18, 2022, a nursing (DON)-B, ir	se (RN) assessment dated and completed by director of dicated R1 required twice t soaks performed by licensed				
	R1's service record diabetic foot soaks.	failed to include twice weekly				
	and therapy plan the required content: (1) a statement of the that would be provided specific resident instantiation of treatments or theration of treatments would be delegated.	an individualized treatment at included the following he type of specific services ded; (2) documentation of structions relating to the py administration; (3) atment or therapy tasks that I to unlicensed personnel res for notifying a registered				

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Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> `´´	E CONSTRUCTION	COMPLETED		
		34175	B. WING		02/0	) 1/ <b>2022</b>
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	•	
KELLER	LAKE COMMONS		MN 55309			
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	professional when a treatments or thera resident specific red	opriate licensed health a problem arose with py services, and; (5) any quirements relating to reatment and therapy received,	01940			
	verification that all tall administered as pre- treatment or therap complications or ad- treatment or therap	reatment and therapy was escribed, and monitoring of y to prevent possible liverse reactions. The y management record must lipidated whenever there				
	to the licensee on Sidiagnoses included neuropathy, chronic 4, chronic obstructive	d was reviewed. R2 admitted September 22, 2021. R2's Type 2 Diabetes, diabetic kidney disease (CKD) Stage ve pulmonary disease ic heart failure (CHF).				
	and completed by Ediabetic foot care. For activities and was in	nt dated January 18, 2022, OON-B, indicated R2 required R2 required oxygen during ndependent in using oxygen positive airway pressure				
	•	ated February 1, 2022, ed assistance with twice daily ks.				
	and therapy plan the required content:  (1) a statement of that would be provided specific resident instantants or therapy plan there.	an individualized treatment at included the following the type of specific services ded; (2) documentation of structions relating to the py administration; (3) atment or therapy tasks that				

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34175	B. WING	_	02/0	) 1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE 5, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
01940	(ULP); (4) procedure nurse (RN) or appropriessional when a treatments or therapy resident specific reducumentation of the verification that all the administered as present the treatment or the rapy complications or additreatment or the rapy be kept current and were changes.  R3 R3's medical record to the licensee on Jacomprehensive hor receiving assisted liagonal limited to Type 2 Dischronic kidney disestibrillation (Afib), an anticoagulants (Couwheelchair and wall with staff assistance R3's RN assessme completed by DON nurse to follow-up of schedule her lab and R3's service plan dar R3'service plan dar R3's service plan dar R3's service plan dar R3's	to unlicensed personnel es for notifying a registered opriate licensed health a problem arose with py services, and; (5) any quirements relating to eatment and therapy received, reatment and therapy was escribed, and monitoring of y to prevent possible verse reactions. The y management record must updated whenever there  I was reviewed. R3 admitted anuary 25, 2021, under the ne care license, and began ving services on August 1, es included, but were not abetes Mellitus with diabetic ase Stage 4, paroxysmal atrial d long-term use of umadin). R3 used a manual ker for mobility and walked e of one using a gait belt.  Int dated July 7, 2021, and eB, indicated R3 required a on new orders as needed, and medical appointments.  Atted August 1, 2021, indicated ance twice daily blood glucose	01940			

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		34175	B. WING			C <b>01/2022</b>	
	PROVIDER OR SUPPLIER	655 NOR	DRESS, CITY, S WOOD LANE E, MN 55309	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
01940	staff's managment of Normalized Ratio (I R3's progress note 10:27 a.m., and write (DON)-B, indicated results. DON-B upon INR results.  R3's record lacked and therapy plan the required content: (specific services the documentation of serelating to the treatment administration; (3) in the trapy tasks that we unlicensed personne notifying a registered licensed health professed with treatment (5) any resident specification that all the treatment or	id not include R3's nursing of R3's International NR).  dated August 28, 2021, at tten by director of nursing she obtained R3's INR lated R3's provider with her  an individualized treatment at included the following 1) a statement of the type of at would be provided; (2) pecific resident instructions					

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D 14/110		С	
		34175	B. WING		02/01/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE 5, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
01940	Continued From pa	ge 54	01940			
		larch 31, 2022, at 11:42 a.m, sted R1, R2 and R3's py plans.				
	DON-B indicated replans were address confirmed in the em	larch 31, 2022, at 2:12 p.m., sident treatment and therapy ed in their service plans, and hail the residents did not have nent or therapy management				
	TIME PERIOD TO	CORRECT: Seven (7) Days				
02360	144G.91 Subd. 8 Fi	reedom from maltreatment	02360			
	sexual, and emotion exploitation; and all	right to be free from physical, nal abuse; neglect; financial forms of maltreatment /ulnerable Adults Act.				
	· •	ent is not met as evidenced				
		` '		No Plan of Correction (PoC) requi Please refer to the public maltreat report (report sent separately) for of this tag.	ment	
	Findings include:					
	Health (MDH) issue occurred, and that the maltreatment, in which occurred at the	e Minnesota Department of ed a determination that neglect he facility was responsible for connection with incidents he facility. The MDH is a preponderance of eatment occurred.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	34175		B. WING		C <b>02/01/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KELLER	LAKE COMMONS		WOOD LANE E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 55	03000			
03000 SS=G		ming of report	03000			
	REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 55  626.557 Subd. 3 Timing of report					

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Minnesota Department of Health

	D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  (X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		24475	B. WING		C 02/01/2022	
		34175	<u></u>		02/0	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE , MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERTION (	D BE	(X5) COMPLETE DATE
03000	determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting to Minneosta Adult Abuse Reporting Center (MAARC) significant medication errors within 24 hours for one of three residents (R1) with records reviewed.  This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).		03000			
	The findings include	<b>3</b> :				
	R1 R1's medical record was reviewed. R1 admitted to the licensee on August 27, 2021. R1's diagnoses included Type 1 diabetes, legal blindness, Fuchs' dystrophy (hereditary eye condition), macular degeneration, and glaucoma.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		<b>,</b> , ,	(X3) DATE SURVEY COMPLETED	
		34175	B. WING	_	02/	C <b>01/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
KELLER	LAKE COMMONS		WOOD LANE			
		BIG LAK	E, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
03000	Continued From pa	ge 57	03000			
	indicated R1 received cares, four times day meals, medication a	ated August 28, 2021, ed assistance with personal aily blood glucose checks, assistance, diabetic foot care, and housekeeping. R1 used a				
	R1's registered nurse (RN) assessment dated September 10, 2021, indicated R1 required supervision with bathing, and stand-by assistance with mobility. R1 was unable to read medication labels due to poor vision. R1 was able to dial the correct number of insulin units on her insulin pens by listening to the clicks on the pens which staff verified and supervised. R1 had partial or total blindness. R1 was assessed as required staff assistance in the event of an emergency.  R1' individual abuse prevention plan (IAPP) dated November 9, 2021, indicated R1 needed assistance with medication administration due to partial or total blindness.					
	dated October and was prescribed the insulin: sodium chlorinstill one drop into (QID). Must wait five moxifloxacin ophthat drop into right eye to prednisolone acetal instill one drop into minutes between distributions and drop BID week, then one drop begin drops three doctober 13, 2021; If apply 1/2 inch ribboth.	November 2021, indicated R1 following eye drops and oride ophthalmic solution, 5%, right eye four times per day e minutes between drops; almic solution, 0.5%, instill one two times per day (BID); te ophthalmic solution 1%, right eye QID. Must wait five ifferent drops; ketorolac 0.5%; in post-operative eye for one p daily for seven more weeks, lays before surgery on Muro 128 5% eye ointment, on to right eye daily, must be last eye drop; Restasis,				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
34175		B. WING		C <b>02/01/2022</b>		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
KELLER	LAKE COMMONS	655 NORV	WOOD LANE			
NELLER	LARE COMMONS	BIG LAKE	, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000	Continued From pa	ge 58	03000			
	administer one drop 8-12 Units, resident per day (TID), staff (long-acting insulin) self-administer once verify dose.	to self-administer three times to verify dose; basaglar 30 Units, resident to e daily (8:00 p.m.), staff to				
	Medication Administration did not receive her dates:  *September 1-16, 2 ophthalmic solution supply  *September 30, 202 ophthalmic solution glucose	ctober, and November 2021 stration Summary, indicated R1 eye drops on the following 2021, 8:00 p.m.: Ketorolac -not administered due to no 21, 8:00 p.m.: Sodium chloride -not administered-high				
	*September 30, 2021, 8:00 p.m.: Muro 128 ophthalmic ointment-declined *October 6, 2021, 8:00 p.m.: Sodium chloride ophthalmic solution-declined *October 14, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-declined *October 15, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-not administered per RN *October 20, 2021, 4:00 p.m.: Sodium chloride ophthalmic solution-declined *October 22, 2021, not on the list *October 30, 2021, 8:00 a.m.: Moxifloxacin ophthalmic solution-unavailable-waiting to receive from pharmacy. *October 30, 2021, 8:00 p.m.: Restasis eyedrops-need refill *November 4-5, 2021: Moxifloxacin ophthalmic solution- (3 missed doses)-no supply *November 5-6 2021: Prednisolone acetate ophthalmic solution (5 missed doses)-no supply The Mayo Clinic website, www.mayoclinic.org, indicated eyedrops immediately after cornea					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		34175	B. WING		1	C <b>01/2022</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE			
		BIG LAKE	, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
03000	control infection, re. The Mayo Clinic we ophthalmic solution anti-inflammatory d pain, burning, and i and after eye surge ophthalmic solution used to draw water Moxifloxacin ophthalmic used to tro Restasis eyedrops inflammation of the ophthalmic solution help prevent inflam transplanted cornea CON April 4, 2021, at (FM)-D stated R1 h she needed to have corneal transplant scall FM-D stating eyedue to DON-B being prescribed eyedrop 2021, she received stating R1 missed to prednisolone ophth were told it was the stated at that point R1 into FM-C's hon facility could be fou documented and key when R1 did not recincluding insulin. FN the state investigated On April 4, 2021, at CON April 4, 2021, at C	and during recovery helped jection, swelling, and pain. ebsite indicated ketorolac was a non-steroidal rug (NSAID) used to treat inflammation of the eye before ries. Sodium chloride and Muro 128 ointment were out of a swollen cornea. Almic solution was an eye eat infections of the eye. were used to prevent cornea. Prenisolone was a corticosteroid used to mation and rejection of the exact infections of the exact infections of the eye. Were used to prevent cornea. Prenisolone was a corticosteroid used to mation and rejection of the exact infection in the exact infection	03000			
eye medications, insulin, and as needed (PRN) medications.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
34175		B. WING		C 02/01/2022		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KELLER	LAKE COMMONS		VOOD LANE			
			, MN 55309			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
03000	On April 5, 2022, at		03000			
	not feel safe when a stating DON-B alwayshe required eye draw corneal transplant a transplant rejection her corneal transplant rejection her corneal transplant personnel (ULP)-E instead of her night dialed up the insuling of her morning insuling wrong insulin.  On April 5, 2022, at personnel (ULP)-E when R1 asked for stated she immediate injected the wrong it told her to monitor for the ullest of the medication error complete an incider had the option of chemical unavailable.  The licensee policy Maltreatment-Preventagust 1, 2021, indicated the medication error complete an incider had the option of chemical and the option of chemical	10:00 a.m., R1 stated she did she resided at the facility, ays made excuses. R1 stated ops before and after her surgery to help prevent. R1 stated the night before ant surgery, unlicensed gave her morning insulin pen time insulin. R1 stated she in pen and administered some lin before realizing it was the  1:00 p.m., unlicensed stated she was distracted her nighttime insulin. ULP-E stelly called DON-B after R1 insulin. ULP-E stated DON-B R1 during the rest of her shift. Ind ULP-J monitored R1 and id sugars at least once after r. ULP-E stated she did not intreport. ULP-E stated staff inarting "declined" or in medications were  titled, Vulnerable Adult ention and Reporting, updated icated the licensee trained all dentifying incidents of ding abuse, financial				
	exploitation, and ne constituted maltrea	glect, and any act that the threat was prohibited.  CORRECT: Seven (7) days.				

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