



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 15, 2025

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

RE: Project Number(s) SL32045016

Dear Licensee:

On September 16, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on July 2, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Renee L. Anderson'.

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 21, 2025

Licensee

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

RE: Project Number(s) SL32045016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

- Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
- Level 3: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

- St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00**
- St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

Keystone Place at LaValle Fields

August 21, 2025

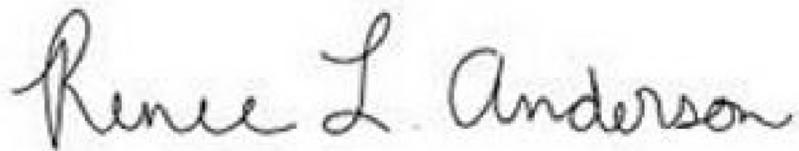
Page 3

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Renee L. Anderson". The signature is written in black ink on a white background.

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2025
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NAME OF PROVIDER OR SUPPLIER KEYSTONE PLACE AT LAVALLE FIEL	STREET ADDRESS, CITY, STATE, ZIP CODE 14602 FINALE AVE N HUGO, MN 55038
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS: SL #32045016-0</p> <p>On June 30, 2025, through July 2, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 99 residents, 69 of whom were receiving services under the provider's Assisted Living Facility with Dementia Care license.</p> <p>On July 1, 2025, an immediate order was issued for tag number 1290.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.</p>	
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that</p>	0 680		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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0 680	<p>Continued From page 1</p> <p>contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;</p> <p>(2) post an emergency disaster plan prominently;</p> <p>(3) provide building emergency exit diagrams to all residents;</p> <p>(4) post emergency exit diagrams on each floor; and</p> <p>(5) have a written policy and procedure regarding missing residents.</p> <p>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in the Appendix Z. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect</p>	0 680		

Minnesota Department of Health

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0 680	<p>Continued From page 2</p> <p>a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's undated EP Plan, lacked evidence of the following required content:</p> <ul style="list-style-type: none"> - documented risk assessment, including various probable risks/hazards by likelihood occurrence; - developed strategies for addressing facility and community-based risks; - policies and Procedures for Volunteers; - roles under a Waiver Declared by Secretary; - emergency prep training and testing; - emergency prep training program, and; - emergency prep testing requirements. <p>On July 2, 2025, at 11:19 a.m., licensed assisted living director (LALD)-A stated they were responsible for the EP plan for the assisted living facility. LALD-A stated they attempted to ensure the EP Plan was compliant but was not able to complete all the required information.</p> <p>The licensee's 9.01 Emergency Preparedness Plan dated March 3, 2023 indicated licensee EP plan would align with the Centers for Medicare and Medicaid Services State Operations Manual - Appendix Z.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 775 SS=F	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter</p>	0 775		

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0 775	<p>Continued From page 3</p> <p>7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 1, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A. The following was observed.</p> <p>FIRE DOOR OPERATION: There were multiple fire doors in the following locations that would not close and latch automatically: 327 unit door, 319 unit door, 216 unit door, 210 unit door, 205 unit door, 227 unit door, 102 unit door, 106 unit door, Sunny Cove 2 unit door, and Sunny Cove double doors.</p> <p>Swinging fire doors shall close from the full-open position and latch automatically.</p> <p>There were multiple fire doors in the following locations that were equipped with kick down door hold open devices that prevented the doors from</p>	0 775		
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0 775	<p>Continued From page 4</p> <p>normal operation: south shore room, 3rd floor tenant laundry room, and northstar room.</p> <p>Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable.</p> <p>CONTROLLED EGRESS DOORS: When interviewed about the magnetic locking system in the memory care unit, LALD-A stated that they were not aware of a button or switch in an approved location that would release the magnetic locks on the exit doors. A switch or button was not able to be located during the tour.</p> <p>The egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 775		
0 790 SS=F	<p>144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment</p> <p>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and</p>	0 790		

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0 790	<p>Continued From page 5</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 1, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-A.</p> <p>The portable fire extinguishers throughout the facility lacked records to show the required annual certification was completed. Service tags on all fire extinguishers had May 2024 marked on them. LALD-A stated that they thought they had been serviced more recently.</p> <p>Portable fire extinguishers are required to be serviced annually.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 790		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and</p>	0 810		

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0 810	<p>Continued From page 6</p> <p>maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <p>(1) location and number of resident sleeping rooms;</p> <p>(2) staff actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.</p> <p>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff,</p>	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 7</p> <p>and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On July 1, 2025, at approximately 1:00 p.m., the surveyor requested documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>Licensed assisted living director (LALD)-A emailed an attachment titled "fire safety" on July 1, 2025, at 1:13 p.m. The attachment was a transcript of a general fire safety video. The transcript included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish/Evacuate), and P.A.S.S (Pull, Aim, Squeeze, and Sweep). The transcript did not contain staff or resident actions to take in a fire or similar emergency.</p> <p>LALD-A provided policy books and indicated they contained the FSEP, training records for both staff and residents, and drills. The provided policy books lacked the facility's FSEP, training records for both staff and residents, and drills.</p> <p>On July 1, 2025, at 2:08 p.m., the surveyor attempted to make a second request for the FSEP, training records for both staff and residents, and fire drills. The surveyor was</p>	0 810		
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0 810	Continued From page 8 informed by front desk staff that LALD-A had left the facility, and were not sure on when they would return. No FSEP, resident or staff training, or fire drills were provided to the surveyor for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff had a cleared Department of Human Services (DHS) NETStudy 2.0 background study, affiliated with the licensee's health facility identification (HFID), prior to having direct contact with residents, for 6 of 9 employees (unlicensed personnel (ULP)-C,	01290		

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01290	<p>Continued From page 9</p> <p>ULP-K, ULP-L, ULP-M, ULP-N, and clinical nurse supervisor (CNS)-B).</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-C, ULP-K, ULP-L ULP-C, ULP-K, and ULP-L were hired to provide direct care services on May 20, 2025, June 9, 2025, and June 18, 2025.</p> <p>On June 30, 2025, at 2:10 p.m., ULP-C was observed, with ULP-D, assisting R2 with incontinence care in R2's apartment.</p> <p>The licensee's employee schedule dated June 1, 2025, through June 30, 2025, indicated the following:</p> <ul style="list-style-type: none"> - ULP-C was scheduled to work 10 shifts; - ULP-K was scheduled to work six shifts; and - ULP-L was scheduled to work four shifts. <p>ULP-C, ULP-K, and ULP-L's employee records lacked a current DHS background study clearance form.</p> <p>The licensee's NETStudy 2.0 background study roster, printed July 1, 2025, indicated the background studies for ULP-C, ULP-K, and ULP-L were all initiated during the survey, on June 30, 2025. The background study was</p>	01290		
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01290	<p>Continued From page 10</p> <p>identified as "In Process" and the roster indicated all three ULPs required direct supervision while working.</p> <p>On July 1, 2025, at 1:11 p.m., CNS-B stated all employees included on the employee list were currently employed by the licensee. CNS-B further stated ULP-C, ULP-K and ULP-L worked independently during their scheduled shifts in June 2025.</p> <p>CNS-B, ULP-M, ULP-N CNS-B was hired June 24, 2016, to provide staff supervision and direct care services under the licensee's previous comprehensive license, and began providing assisted living services on August 1, 2021.</p> <p>The Minnesota (MN) Board of Nursing (BON) database, accessed July 1, 2025, indicated CNS-B was licensed as a Registered Nurse (RN) on February 21, 2001, prior to the 2018 addition of fingerprinting as a requirement for RN licensure in MN.</p> <p>On July 1, 2025, at approximately 1:00 p.m., and during the course of the survey, CNS-B accessed and provided the surveyor with requested information from resident records.</p> <p>ULP-M and ULP-N were hired, under the licensee's previous comprehensive license, November 10, 2020, and May 5, 2017, respectively, to provide direct care services for residents. ULP-M and ULP-N began providing services under the licensee's Assisted Living Facility license on August 1, 2021.</p> <p>CNS-B, ULP-M, and ULP-N's records lacked a current DHS background study clearance form</p>	01290		

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01290	<p>Continued From page 11</p> <p>associated with the licensee's current HFID, 32045.</p> <p>The licensee's NETStudy 2.0 background study roster printed July 1, 2025, did not include CNS-B, ULP-M, or ULP-N.</p> <p>On July 1, 2025, at 1:35 p.m., licensed assisted living director (LALD)-A stated they were responsible for the background studies for the licensee. LALD-A stated when the licensee converted from a comprehensive home care license to the assisted living license, a new HFID was issued and they no longer had access to background studies completed under the old HFID. LALD-A stated they thought NETStudy was going to affiliate all the staff from the previous license to the new license.</p> <p>The licensee's 4.02 Background Studies policy, dated April 19, 2022, indicated "using the MN DHS NetStudy online program, (licensee) will initiate a background study on all employees being considered for hire. If hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hire shall not be permitted to interact or provide services to tenants or clients of (licensee) except under the direct supervision (eyesight) of another qualified staff person."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: IMMEDIATE</p>	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	<p>Continued From page 12</p> <p>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.</p> <p>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing delegated tasks, within 30 calendar days after the date on which they began working for the facility and first performed the delegated tasks for residents, for two of two employees (unlicensed personnel (ULP)-E, ULP-I).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and</p>	01440		

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01440	<p>Continued From page 13</p> <p>was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-E ULP-E had a hire date of July 29, 2023, and provided direct care services for residents.</p> <p>On July 1, 2025, at 7:00 a.m., the surveyor observed ULP-E assisting R6 with dressing, transferring and grooming. At 7:50 a.m., the surveyor observed ULP-E assisting R7 with incontinence care, dressing, grooming and transferring.</p> <p>ULP-I ULP-I had a hire date of July 15, 2024, and provided direct care services for residents.</p> <p>On July 1, 2025, at 7:30 a.m., the surveyor observed ULP-I assisting R6 with medication administration.</p> <p>ULP-E and ULP-I's records lacked documentation the RN conducted direct supervision within 30 days of ULP-E and ULP-I performing delegated tasks.</p> <p>On July 2, 2025, at 11:55 a.m., clinical nurse supervisor (CNS)-B stated the 30-day supervision had not been completed for ULP-E or ULP-I. CNS-B further stated she thought they had been done and she was not sure why they were missed.</p> <p>The licensee's 6.17 Supervision of Staff-Delegated Services policy, dated April 19,</p>	01440		

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01440	Continued From page 14 2022, indicated, "Direct supervision of staff performing delegated tasks must be provided within 30 days after the date on which the staff begins working for [licensee], and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with	01500		

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01500	<p>Continued From page 15</p> <p>residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees completed eight hours annual training including all required topics for each 12 months of employment for one of three employees (licensed practical nurse (LPN)-F).</p>	01500		

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01500	<p>Continued From page 16</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).</p> <p>The findings include:</p> <p>LPN-F was hired October 23, 2023, and provided direct care services to residents and supervision to staff.</p> <p>On July 1, 2025, at 8:25 a.m., the surveyor observed LPN-F assisting R6 with eating breakfast.</p> <p>LPN-F's employee record lacked documentation the employee had successfully completed at least eight hours of annual training for every 12 months of employment as required under 144G.63, Subd.5, to include the following: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights.</p> <p>On July 2, 2025, at 1:43 p.m., licensed assisted living director (LALD)-A stated it looked like LPN-F had not completed the required annual training. LALD-A further stated it looked like LPN-F had been assigned the training and "didn't do it."</p> <p>The licensee's 5.06 Annual Required Staff Training policy, dated April 19, 2022, indicated annual training would include all the required topics as required under 144G.63, Subd.5.</p>	01500		

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01500	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=D	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.</p>	01620		

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01620	<p>Continued From page 18</p> <p>(e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the start of services for one of four residents (R4).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include: R4 was admitted April 28, 2025.</p>	01620		

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01620	<p>Continued From page 19</p> <p>R4's service plan, dated May 14, 2025, indicated R4 received services including assistance with medication management.</p> <p>On July 2, 2025, at 11:20 a.m., the surveyor observed R4 participating in a group exercise activity.</p> <p>R4's record included an initial comprehensive nursing assessment, dated April 28, 2025, and a subsequent RN reassessment, dated May 28, 2025 (16 days past the 14-day due date).</p> <p>On July 2, 2025, at 2:10 p.m., clinical nurse supervisor (CNS)-B stated R4's 14-day assessment was completed late, and she was unsure why. CNS-B further stated it "must have gotten missed."</p> <p>The licensee's 6.01 Assessments Reviews & Monitoring policy, dated April 19, 2022, indicated the RN would conduct a monitoring and reassessment no more than 14 days after the initiation of assisted living services.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		
01640 SS=D	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the</p>	01640		

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01640	<p>Continued From page 20</p> <p>facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days of start of services for one of three residents (R3).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).</p> <p>The findings include:</p> <p>R3 began receiving assisted living services on February 26, 2024.</p> <p>R3's record included a signed service plan dated</p>	01640		
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01640	<p>Continued From page 21</p> <p>March 20, 2024, 23 days after admission. The service plan indicated R3 received services including assistance with medication administration.</p> <p>On July 1, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated the service plan for R3 had been signed late. CNS-B further stated she had been on vacation when R3 was admitted, and she was not sure why the nurse who was working did not get the service plan signed on time.</p> <p>The licensee's 6.08 Service Plan policy dated April 19, 2022, indicated a finalized service plan would be completed no later than 14 days after initiation of services.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01640		
01650 SS=F	<p>144G.70 Subd. 4 (f) Service plan, implementation and revisions to</p> <p>(f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service</p>	01650		

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NAME OF PROVIDER OR SUPPLIER KEYSTONE PLACE AT LAVALLE FIEL	STREET ADDRESS, CITY, STATE, ZIP CODE 14602 FINALE AVE N HUGO, MN 55038
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	<p>Continued From page 22</p> <p>cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R2, R3, R4, R5).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2, R3, R4, R5's service plans were dated April 2, 2025, March 20, 2024, May 14, 2024, and May 4, 2025, respectively. R2, R3, R4, R5's service plans all indicated the residents received services including assistance with medication</p>	01650		

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01650	<p>Continued From page 23</p> <p>administration.</p> <p>On June 30, 2025, at 1:25 p.m., unlicensed personnel (ULP)-I was observed assisting R2 with medication administration.</p> <p>On June 30, 2025, at 2:10 p.m., ULP-C and ULP-D were observed assisting R3 with personal cares.</p> <p>R2, R3, R4, R5's service plans all lacked the following required content: - the schedule and methods of monitoring staff providing services.</p> <p>On July 2, 2025, at 12:50 p.m., clinical nurse supervisor (CNS)-B stated the registered nurses (RN) were responsible for the service plan content for each resident. CNS-B further stated they were unaware of all the required content for the Service Plan.</p> <p>The licensee's 6.08 Service Plan policy dated April 19, 2022, indicated each Service Plan would contain the content listed above.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01650		
01760 SS=D	<p>144G.71 Subd. 8 Documentation of administration of medication</p> <p>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation</p>	01760		

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01760	<p>Continued From page 24</p> <p>must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff accurately documented medications administered as prescribed for one of one staff (ULP-G).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R5's service plan, dated May 4, 2025, indicated R5 received services including assistance with medication administration.</p> <p>R5's medication administration record (MAR) for July 2025, indicated R5 was scheduled the following medications: -aspirin 81 milligrams (mg) 1 tablet once daily, -metformin 500 mg 1 tablet once daily, -pregabalin 75 1 tablet once daily, -Wixela inhaler 1 puff twice daily,</p>	01760		
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Minnesota Department of Health

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01760	<p>Continued From page 25</p> <ul style="list-style-type: none"> -sertraline 100 mg 2 tablets once daily, -mirabegron 25 mg 1 capsule once daily, -potassium chloride 20 milligram equivalents (meq), -cetirizine 10 mg 1 tablet once daily, -magnesium oxide 140 mg 2 tablets once daily, -Flonase 50 milligrams (mcg) 2 sprays into the nose once daily, -acetaminophen 500 mg 2 tablets three times daily, -loperamide 2 mg 1 tablet once daily, -lidocaine patch apply to the lower back as needed, -nystatin powder apply to the groin area as needed, -ipratropium bromide 0.03 % 2 sprays three times into the nose as needed, and -guaifenesin 600 mg 1 tablet twice daily as needed. <p>On July 1, 2025, at 9:35 a.m., the surveyor observed ULP-G assisting R5 with medication administration. ULP-G removed a pill box container from the medication cart. ULP-G opened the container section labeled "Morn Tues", and poured the content into a medication cup. Without verifying the medications with the MAR, ULP-G administered the medications to R5.</p> <p>On July 1, 2025, at 9:42 a.m., ULP-G stated R5 was the only resident whose medications were setup in a pill box container. ULP-G stated they were trained to place R5's medications from the pill container into the medication cup and administer. ULP-G stated they were not trained to count the medications.</p> <p>On July 1, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to</p>	01760		

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01760	<p>Continued From page 26</p> <p>count the number of medications in the medication pill container and compare that count to the medications listed on the electronic medication administration record (EMAR). CNS-B stated if ULP-G did not count the medications and compared that number to the EMAR then the medications were not verified prior to administration.</p> <p>The licensee's 7.08 Medication Management - Administration and Setup policy dated April 19, 2022, indicated required staff to verify medications stored in a pill container prior to administering the medications.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01760		
01880 SS=D	<p>144G.71 Subd. 19 Storage of medications</p> <p>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in a substantially constructed compartment for one of four residents (R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a</p>	01880		

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01880	<p>Continued From page 27</p> <p>resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2 had diagnoses including Parkinson's disease (a movement disorder of the nervous system) and dementia (decline in cognitive function).</p> <p>R2's signed service plan, dated April 2, 2025, indicated R2 received services including assistance with medication management.</p> <p>R2's nursing assessment, dated April 2, 2025, indicated R2 was unable to self-administer medications, and all medications were stored in locked medication carts.</p> <p>R2's medication administration record for June 2025, indicated R2 was scheduled the following medications:</p> <ul style="list-style-type: none"> -Sarna sensitive lotion (used to treat eczema and dry sensitive skin) daily at 8:00 a.m. and 8:00 p.m. -nystatin powder (antifungal powder used for skin irritation) daily at 8:00 a.m. and 8:00 p.m. <p>On June 30, 2025, at 2:10 p.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-D assisting R2 with cares in bed. The surveyor further observed R2's nightstand which contained a bottle of nystatin powder and a bottle of Sarna pramoxine hydrochloride 1% external analgesic lotion. ULP-D stated she did not think the medications should be on R2's nightstand.</p>	01880		

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01880	<p>Continued From page 28</p> <p>On July 1, 2025, at 11:45 a.m., licensed practical nurse (LPN)-F stated normally medications were not left on the residents' nightstands and they may have been left there by the morning staff.</p> <p>On July 2, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-B stated medications should not be left unattended in any of the dementia care resident rooms.</p> <p>The licensee's 7.11 Medication Storage Policy, dated April 19, 2022, indicated medications would be stored consistent with each resident' medication management plan. The policy further indicated medications managed outside of a residents private living space must be securely locked in a medication room, medication cart, or similar setup.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01880		
02040 SS=F	<p>144G.81 Subdivision 1 Fire protection and physical environment</p> <p>An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.</p>	02040		

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02040	<p>Continued From page 29</p> <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On July 1, 2025, at approximately 1:00 p.m., the surveyor requested the facility safety risk assessment on and around the property as well as mitigating factors of the identified risks.</p> <p>Licensed assisted living director (LALD)-A provided policy books and indicated they contained the facilities safety risk assessment on and around the property as well as mitigating factors. The provided policy books lacked the facility's safety risk assessment on and around the property as well as mitigating factors.</p> <p>On July 1, 2025, at 2:08 p.m., the surveyor attempted to make a second request for the licensee's safety risk assessment on and around the property as well as mitigating factors. The</p>	02040		
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02040	<p>Continued From page 30</p> <p>surveyor was informed by front desk staff that LALD-A had left the facility, and were not sure on when they would return.</p> <p>No safety risk assessment on and around the property as well as mitigating factors was provided to the surveyor for review.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	02040		



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Keystone Place At Lavalley Fiel
14602 Finale Avenue North
Hugo, MN 55038
Washington County
Parcel:

Phone:

License Info

License: HFID 32045

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1031251040
Inspection Type: Full - Single
Date: 7/1/2025 Time: 8:30am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Visit conducted as part of an HRD survey. Food service is being conducted by a contracted company - New Horizon Foods. Establishment is also currently licensed by Washington County.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1031251040 from 7/1/2025

Terese Bownik
Director of Operations

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us