



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 16, 2025

Licensee
Stoney River Ramsey
14401 Nowthen Boulevard Northwest
Ramsey, MN 55303

RE: Project Number(s) SL31334016

Dear Licensee:

On March 19, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 20, 2024. 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 cursive script that reads 'Jessica Chenze'.

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 11, 2025

Licensee
Stoney River Ramsey
14401 Nowthen Boulevard Northwest
Ramsey, MN 55303

RE: Project Number(s) SL31334016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 20, 2024, 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 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

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

Level 4: a fine of \$5,000 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:

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$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

Stoney River Ramsey

February 11, 2025

Page 3

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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 "Jessica Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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:</p> <p>SL31334016-0</p> <p>On December 16, 2024, through December 20, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 75 residents; 55 receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>An immediate correction order was identified on December 18, 2024, issued for SL31334016-0, tag identification 2310.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</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.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
0 510 SS=F	<p>144G.41 Subd. 3 Infection control program</p> <p>(a) All assisted living facilities must establish and</p>	0 510		

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

0 510	<p>Continued From page 1</p> <p>maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for two of two employees (unlicensed personnel (ULP)-G, ULP-H) observed to provide personal cares.</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 the residents).</p> <p>The findings include:</p> <p>On December 18, 2024, at 10:12 a.m., with R6's permission, the surveyor observed while ULP-G performed personal cares and prepared to transfer R6 from the bed to the toilet. ULP-G gathered R6's clothing and brief. ULP-G stated R6 required assistance of two staff, covered R6</p>	0 510		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

0 510	<p>Continued From page 2</p> <p>with her blanket, and told R6 she would be back. ULP-G left the room, and returned with ULP-H. ULP-G and ULP-H donned (put on) gloves. ULP-H unfastened R6's brief and used disposable wipes to clean between R6's thighs and buttocks, while ULP-G slid pull-up style brief and pants onto R6's lower legs. Without removing soiled gloves, ULP-H assisted to transfer R6 by bringing sit-to-stand lift to R6's bedside, assisting R6 to stand, and transferring to the toilet. ULP-H then removed the gloves, and without performing hand hygiene, opened R6's apartment door and walked into the common area. The surveyor stopped ULP-H, whom stated hand hygiene should have been performed. At 10:32 a.m., ULP-G continued to provide personal cares to R6 while R6 sat on the toilet. ULP-G donned clean gloves and used a washcloth to assist R6 to wash her face. ULP-G removed the gloves, washed her hands in the bathroom sink, and looked around to find something to dry her hands on. ULP-G reached for a used cloth that was hanging on the safety handrail in R6's shower, dried her hands, and donned clean gloves. ULP-H returned to the room and ULP-G and ULP-H attempted to assist R6 to stand. R6 resisted, was tearful, and complained of pain. ULP-I and an unidentified female knocked and entered R6's apartment, and after discussion of R6's complaints of pain and difficulty with standing, ULP-G asked them to get the nurse. Registered nurse (RN)-J entered R6's apartment, donned gloves, and RN-J and ULP-H assisted R6 to stand, while ULP-G used a disposable wipe to clean between R6's thighs and buttocks. Without removing the gloves, ULP-G straightened R6's bathroom, putting items away, combed R6's hair, and pulled R6's visibly soiled mattress pad off of the bed. Still without removing the gloves, ULP-G reached on top of the portable closet in R6's room, grabbed linens, and made</p>	0 510		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 510	<p>Continued From page 3</p> <p>R6's bed. ULP-G removed the gloves, tossed into the garbage can, and without performing hand hygiene, pushed R6 out of the apartment, into the dining room. ULP-G washed her hands in the kitchen sink.</p> <p>On December 18, 2024, at 11:07 a.m., ULP-G stated she was trained to remove her gloves after providing personal cares and stated she should have done that and washed her hands after removing the gloves.</p> <p>Review of ULP-G's education transcript, printed December 20, 2024, indicated ULP-G completed Hand Hygiene Basics on December 3, 2024.</p> <p>On December 18, 2024, at 3:07 p.m., clinical nurse supervisor (CNS)-A stated staff were expected to perform hand hygiene after performing personal cares and when removing gloves, before touching other items. CNS-A stated gloves should always be removed after touching "dirty areas," and hands should be washed before donning clean gloves. CNS-A stated hand hygiene was discussed at monthly meetings and spot checks were being completed.</p> <p>The licensee's Procedure for Using Gloves policy, dated June 19, 2023, indicated gloves would be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. The policy directed gloves would be removed carefully, disposed of in a proper container, and hands would be washed.</p> <p>The licensee's Hand Hygiene policy, dated June 19, 2023, indicated hand washing shall be performed between resident cares and whenever</p>	0 510		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 510	<p>Continued From page 4</p> <p>direct physical contact with a resident takes place. The policy directed hands should be washed or decontaminated:</p> <ul style="list-style-type: none"> - before and after direct contact with a resident; - if moving from a contaminated body site to a clean body site during resident care; - after contact with environmental surfaces or equipment in the immediate vicinity of the resident; - after removing gloves or gowns; and - before eating and after using a restroom. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 510		
0 640 SS=F	<p>144G.42 Subd. 7 Posting information for reporting suspected c</p> <p>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:</p> <ol style="list-style-type: none"> (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common</p>	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

0 640	<p>Continued From page 5</p> <p>areas and near telephones provided by the facility, as required. 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 a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the initial tour on December 16, 2024, at 12:07 p.m., with sales/marketing director (SMD)-D, the surveyor observed the main entry area of the facility and postings in common areas throughout the facility. The surveyor did not observe the 911 emergency number posted.</p> <p>On December 16, 2024, at 2:55 p.m., licensed assisted living director (LALD)-B stated the 911 emergency number was not posted in common areas or near facility telephones, as required.</p> <p>The licensee's Vulnerable Adult Maltreatment Policy, dated June 19, 2023, indicated staff should call 911 immediately if they witnessed an incident or allegation of maltreatment, however, the policy did not direct posting the 911 emergency number in common areas and near telephones provided by the facility, as required.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 640		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

0 650 SS=D	<p>144G.42 Subd. 8 (a) Staff records</p> <p>(a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two unlicensed personnel, (ULP)-F.</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</p>	0 650		
---------------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

0 650	<p>Continued From page 7</p> <p>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>ULP-F had a start date of August 27, 2024.</p> <p>ULP-F's record included Medication Pass Competency, dated September 18, 2024. The document included steps of administration of medication, with check marks under "yes" for each step, to indicate ULP-F passed each competency. The document lacked a signature by the registered nurse (RN) whom observed and evaluated ULP-F's medication administration competency.</p> <p>ULP-F's record lacked evidence of the following: - records of orientation and competency evaluations.</p> <p>On December 20, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-A stated ULP-F passed the medication administration competency evaluation by a RN, and would not be passing medications if that had not happened. CNS-A stated the RN did not sign the document and should have.</p> <p>The licensee's Training Unlicensed Personnel for Medication, Treatment, and Therapy Administration policy, dated June 19, 2023, indicated the RN would document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff person's personnel record.</p> <p>The licensee's Training Documentation policy,</p>	0 650		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 650	Continued From page 8 dated June 19, 2023, indicated a record of staff training and competency would be maintained and would include the instructor's signature and title. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that 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; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (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. (c) The facility must meet any additional requirements adopted in rule.	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

0 680	<p>Continued From page 9</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post an emergency preparedness plan prominently, and failed to post emergency exit diagrams on each floor, as required. 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 is 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>During the initial tour on December 16, 2024, at 12:07 p.m., with sales/marketing director (SMD)-D, the surveyor observed the main entry area of the facility and common areas on each floor, throughout the facility. The surveyor did not observe the emergency preparedness plan or emergency exit diagrams.</p> <p>On December 16, 2024, at 2:55 p.m., licensed assisted living director (LALD)-B stated the licensee's Emergency Preparedness Plan was kept in her office and was not currently posted prominently because they were trying to figure out how to make a smaller version of the plan, and stated they didn't have emergency exit diagrams posted because they were considering having them "remade."</p> <p>No further information was provided.</p>	0 680		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 680	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

0 730	<p>Continued From page 11</p> <p>(11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (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 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>R4's diagnoses included type 2 diabetes, sepsis (infection in the blood stream), dementia, and psychotic disturbance.</p> <p>R4 began receiving services on August 30, 2022, and was discharged on June 19, 2024.</p> <p>R4's progress notes, dated June 19, 2024,</p>	0 730		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 730	<p>Continued From page 12</p> <p>indicated R4 left the facility with a family member and was taken to a new facility.</p> <p>R4's record lacked a discharge summary.</p> <p>On December 18, 2024, at 5:15 p.m., clinical nurse supervisor (CNS)-A stated no discharge summary was completed for R4, as required. CNS-A stated all he could find was that R4 was discharged from the facility in the progress notes. CNS-A could not provide an example of a completed discharge summary.</p> <p>The licensee's Resident Record policy, revised October 2024, indicated the licensee would maintain a record for each resident in accordance with regulatory standards, and would include a discharge summary, including service termination notice and related documentation when applicable.</p> <p>The licensee's Discharge Summary policy, dated June 19, 2023, indicated a discharge summary would be written at the time of discharge, and would be provided to the resident, and with consent, to the resident's representative and case manager at the time of discharge.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days</p>	0 730		
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 maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 810	<p>Continued From page 13</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 observation, 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, and visitors.</p> <p>This practice resulted in a level two violation (a</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 810	<p>Continued From page 14</p> <p>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 December 17, 2024, at 11:45 a.m., maintenance manager (MM)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency.</p> <p>Fire safety evacuation maps were not posted on each floor.</p> <p>DRILLS:</p> <p>The licensee stated that they conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Upon record review of licensee's evacuation drill</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 810	<p>Continued From page 15</p> <p>log indicated evacuation drills were conducted on April 30, 2024, and August 20, 2024. No other documentation was provided.</p> <p>TRAINING:</p> <p>The licensee failed to provide training to employees on the fire safety and evacuation upon hire and at least twice per year. No training documentation was provided.</p> <p>The licensee stated they provide evacuation training to residents at least once per year but lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.</p> <p>MM-C stated that they were doing the training, and he understood the requirements for training residents and staff but was unable to provide the documentation for this.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	0 810		
0 970 SS=C	<p>144G.50 Subd. 5 Waivers of liability prohibited</p> <p>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.</p>	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 970	<p>Continued From page 16</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for personal property of a resident. This had the potential to affect all current residents.</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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 the residents).</p> <p>The findings include:</p> <p>The [licensee] Assisted Living & Memory Care Resident Agreement, dated June 1, 2023, included the following clause which indicated the resident would waive the licensee's liability for personal property of the resident: -On page 13 of the contract, section "19. DISCLAIMERS" included. "A. Personal Property. [Licensee] does not insure, nor does it take responsibility for your personal property. We recommend you use proper precautions to guard yourself against possible loss, which may include obtaining renters' insurance." Also included, "[Licensee] insures itself against liability losses. It does not insure Residents for liability losses. We recommend you use proper precautions to guard yourself against possible loss."</p> <p>On December 19, 2024, at 2:46 p.m., licensed assisted living director (LALD)-B stated the licensee was using a contract received from a</p>	0 970		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
0 970	Continued From page 17 provider group, so stated she was surprised that the contract was not correct. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01060	<p>Continued From page 18</p> <p>(1) the resident, legal representative, and designated representative;</p> <p>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and</p> <p>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.</p> <p>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R2) whom was hospitalized.</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>R2 began receiving assisted living services on October 17, 2024.</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01060	<p>Continued From page 19</p> <p>R2's Progress Notes, dated October 25, 2024, indicated R2 complained of increased left hip pain. R2 was transported to the hospital per family member's direction. R2's Progress Notes, dated November 6, 2024, indicated R2 returned to the facility from the hospital, after surgical repair of femur fracture.</p> <p>R2's record lacked evidence of an emergency relocation notice, as required.</p> <p>On December 17, 2024, at 3:00 p.m., clinical nurse supervisor (CNS)-A provided an emergency relocation form that the licensee uses, but stated they are only completed for residents that would have a "psych type" admission, not when being admitted to a hospital for a medical reason. CNS-A stated there was no emergency relocation form completed for R2, and stated the OOLTC was not notified when R2 did not return to the facility within four days, as required.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01060		
01370 SS=F	<p>144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn</p> <p>(a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens;</p>	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01370	<p>Continued From page 20</p> <p>(4) maintenance of a clean and safe environment;</p> <p>(5) appropriate and safe techniques in personal hygiene and grooming, including:</p> <p>(i) hair care and bathing;</p> <p>(ii) care of teeth, gums, and oral prosthetic devices;</p> <p>(iii) care and use of hearing aids; and</p> <p>(iv) dressing and assisting with toileting;</p> <p>(6) training on the prevention of falls;</p> <p>(7) standby assistance techniques and how to perform them;</p> <p>(8) medication, exercise, and treatment reminders;</p> <p>(9) basic nutrition, meal preparation, food safety, and assistance with eating;</p> <p>(10) preparation of modified diets as ordered by a licensed health professional;</p> <p>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;</p> <p>(12) awareness of confidentiality and privacy;</p> <p>(13) understanding appropriate boundaries between staff and residents and the resident's family;</p> <p>(14) procedures to use in handling various emergency situations; and</p> <p>(15) awareness of commonly used health technology equipment and assistive devices.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-F, ULP-G) to include all required content. This had the potential to affect all of the licensee's residents.</p>	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01370	<p>Continued From page 21</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>ULP-F ULP-F was hired on August 27, 2024, to provide direct care services to residents of the facility.</p> <p>ULP-F's employee record lacked documentation of training and competency evaluations for the following:</p> <ul style="list-style-type: none"> - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - care and use of hearing aids; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - preparation of modified diets as ordered by a licensed health professional; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. <p>ULP-G ULP-G was hired on October 3, 2023, to provide direct care services to residents of the facility.</p> <p>ULP-G's employee record lacked documentation of training and competency evaluations for the</p>	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

01370	<p>Continued From page 22</p> <p>following:</p> <ul style="list-style-type: none"> - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - appropriate and safe techniques in personal hygiene and grooming, including: <ul style="list-style-type: none"> - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. <p>On December 20, 2024, at 12:13 p.m., licensed assisted living director (LALD)-B stated she wasn't able to locate ULP-F and ULP-G's competency evaluation documentation.</p> <p>On December 20, 2024, at 12:38 p.m., clinical nurse supervisor (CNS)-A stated he was unable to provide documentation to verify ULP-F and ULP-G completed training and competency evaluation for the above contents.</p> <p>The licensee's Qualifications, Training, and Competency policy, dated 2020, indicated the registered nurse must ensure that the ULP was trained in the proper methods to perform the tasks or procedures for each resident and were able to demonstrate the ability to competently</p>	01370		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01370	<p>Continued From page 23</p> <p>follow the procedures and perform the tasks, including:</p> <ul style="list-style-type: none"> - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: <ul style="list-style-type: none"> - hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01370		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01380	Continued From page 24	01380		
01380 SS=F	<p>144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn</p> <p>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:</p> <ol style="list-style-type: none"> (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for two of two unlicensed personnel (ULP-F, ULP-G) to include all required content. This had the potential to affect all of the licensee's 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>	01380		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

01380	<p>Continued From page 25</p> <p>The findings include:</p> <p>ULP-F ULP-F was hired on August 27, 2024, to provide direct care services to residents of the facility.</p> <p>ULP-G ULP-G was hired on October 3, 2023, to provide direct care services to residents of the facility.</p> <p>ULP-F and ULP-G's employee records lacked documentation of training and competency evaluations for the following:</p> <ul style="list-style-type: none"> - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. <p>On December 20, 2024, at 12:13 p.m., licensed assisted living director (LALD)-B stated she wasn't able to locate ULP-F and ULP-G's competency evaluation documentation.</p> <p>On December 20, 2024, at 12:38 p.m., clinical nurse supervisor (CNS)-A stated he was unable to provide documentation to verify ULP-F and ULP-G completed training and competency evaluation for the above contents.</p>	01380		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01380	<p>Continued From page 26</p> <p>The licensee's Qualifications, Training, and Competency policy, dated 2020, indicated the registered nurse must ensure that the ULP was trained in the proper methods to perform the tasks or procedures for each resident and were able to demonstrate the ability to competently follow the procedures and perform the tasks, including:</p> <ul style="list-style-type: none"> - observation, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; - range of motioning and positioning; and - administering medications or treatments as required. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01380		
01440 SS=F	<p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</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</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01440	<p>Continued From page 27</p> <p>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 interview and record review, the licensee failed to ensure a registered nurse (RN) conducted supervision of unlicensed staff as required for two of two unlicensed personnel (ULP -F, 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 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: ULP-F ULP-F had a hire date of August 27, 2024.</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01440	<p>Continued From page 28</p> <p>On December 17, 2024, at 12:10 p.m., the surveyor observed while ULP-F prepared to serve lunch to residents in the dementia care unit. ULP-F stated she was responsible for administering medications to the residents she was caring for that day.</p> <p>ULP-F's record lacked evidence an RN conducted direct supervision of ULP-F within 30 days of performing delegated tasks.</p> <p>ULP-G ULP-G had a hire date of October 3, 2023.</p> <p>On December 18, 2024, at 9:53 a.m., the surveyor observed as ULP-G prepared and administered medications to R2.</p> <p>ULP-G's record lacked evidence an RN conducted direct supervision of ULP-G within 30 days of performing delegated tasks.</p> <p>On December 20, 2024, at 11:46 a.m., clinical nurse supervisor (CNS)-A stated he was unable to provide documentation of supervision within 30 days of performing delegated tasks for ULP-F and ULP-G, as required, and was unable to explain why the supervision did not occur.</p> <p>The licensee's Supervision of Unlicensed Personnel policy, dated June 19, 2023, included, "Direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned."</p> <p>No further information was provided.</p>	01440		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01440	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=F	<p>144G.63 Subd. 2 Content of required orientation</p> <p>(a) The orientation must contain the following topics:</p> <ol style="list-style-type: none"> (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. <p>(b) In addition to the topics in paragraph (a),</p>	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

01470	<p>Continued From page 30</p> <p>orientation 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 the challenges it poses to communication;</p> <p>(2) 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 interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one employee (unlicensed personnel (ULP)-F).</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</p>	01470		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01470	<p>Continued From page 31 of the residents).</p> <p>The findings include:</p> <p>ULP-F was hired on August 27, 2024, to provide direct care services to residents of the facility.</p> <p>ULP-L's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following:</p> <ul style="list-style-type: none"> - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - principles of person-centered planning/service delivery. <p>On December 20, 2024, at 12:38 p.m., clinical nurse supervisor (CNS)-A stated he was unable to verify ULP-F had the above training, as required.</p> <p>The licensee's Assisted Living Orientation-ULP Staff, dated June 19, 2023, indicated ULPs would receive training with a written or oral competency test including:</p> <ul style="list-style-type: none"> - person-centered care and service delivery including how they apply to direct support services. <p>The policy did not indicate the orientation would include a review of the facility's policies and procedures.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01470		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01500	Continued From page 32	01500		
01500 SS=F	<p>144G.63 Subd. 5 Required annual training</p> <p>(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:</p> <ul style="list-style-type: none"> (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 residents who have dementia, Alzheimer's disease, or related disorders; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.</p>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01500	<p>Continued From page 33</p> <p>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 interview and record review, the licensee failed to ensure annual training including all required topics for each twelve months of employment for two of two employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-G). This had the potential to affect all of the licensee's 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>	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01500	<p>Continued From page 34</p> <p>CNS-A CNS-A began his employment with the licensee on November 14, 2022, to provide direct service to the licensee's residents and supervision of the licensee's staff.</p> <p>ULP-G ULP-G was hired on October 3, 2023, to provide direct care services to residents of the facility.</p> <p>CNS-A and ULP-G's employee records lacked the following required annual training content: - 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 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>On December 20, 2024, at 12:38 p.m., clinical nurse supervisor (CNS)-A stated he was unable to verify if he and ULP-G had the above training, as required.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01500		
01620 SS=E	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 35</p> <p>resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) 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>(e) 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 the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services for one of three residents (R1), and failed to complete a reassessment not to exceed 90 days, as required, for two of three residents (R1, 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 36</p> <p>The findings include:</p> <p>During the entrance conference on December 16, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated his understanding was assessments should be completed preadmission, upon admission, 14 days, and then every 90 days or when there was a change of condition.</p> <p>R1 R1 was admitted for services on February 13, 2024.</p> <p>R1's diagnoses included type 2 diabetes and ketoacidosis (serious complication of diabetes).</p> <p>R1's service plan, signed by R1 on December 6, 2024, indicated R1 received assistance with managing transportation, bathing, medication management, safety checks every shift, monthly vitals, fall interventions, and assistance with insulin and blood sugar checks.</p> <p>On December 18, 2024, at 4:27 p.m., with permission from R1, the surveyor observed while unlicensed personnel (ULP)-F checked R1's blood sugar.</p> <p>R1's record included an initial assessment, dated February 13, 2024, on the day R1 was admitted. R1's reassessment was initiated on March 27, 2024 (43 days later), and not completed in the electronic system until April 23, 2024, therefore, lacked a reassessment and monitoring no more than 14 calendar days after initiation of services. R1's ongoing resident assessments were dated May 28, 2024, August 29, 2024, and December 3, 2024 (96 days later), therefore, exceeding 90 calendar days from the last date of the</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 37</p> <p>assessment.</p> <p>R3 R3 was admitted for services on May 9, 2015.</p> <p>R3's diagnoses included Alzheimer's disease with behavioral disturbance, depressive episodes, and high blood pressure.</p> <p>R3's unsigned service plan, last revised December 16, 2024, indicated R3 required assistance with toileting, behavior management, monthly vitals, escorts to and assistance with activities, hourly safety checks, fall interventions, turning and repositioning, pain management, bathing, cognition, housekeeping, medication management, dressing, laundry, meals, personal hygiene, mobility, and transferring.</p> <p>On December 17, 2024, at 12:27 p.m., the surveyor observed while R3 was pushed to the dining room table in her geriatric chair by an unidentified ULP, and ULP-F placed a clothing protector on R3 and announced that it was time to eat.</p> <p>R3's record included ongoing resident assessments, dated June 12, 2023, November 5, 2023, (146 days later), and August 6, 2024 (275 days later). R3's record lacked any further assessments, therefore, lacking ongoing resident reassessment and monitoring based on changes in the needs of the resident, not to exceed 90 calendar days from the last date of the assessment.</p> <p>On December 20, 2024, at 11:04 a.m., CNS-A stated he could not locate any other assessments for R1 and R3, and stated, "What is there [in electronic medical record], is there." CNS-A also</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 38</p> <p>stated, "Most of the time, we get them done on time." CNS-A stated the above assessments were not completed timely per the regulations.</p> <p>The licensee's Resident Initial and On-going Assessments policy, dated June 19, 2023, indicated a registered nurse (RN) would complete comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required, including a pre-admission assessment, 14 day assessment completed up to 14 days after start of services, ongoing assessment completed periodically but no less than every 90 days, and change in resident condition.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		
01640 SS=E	<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 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</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01640	<p>Continued From page 39</p> <p>services required by the current service plan. (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. (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 ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for two of three residents (R2, 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, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R2 R2 was admitted for services on October 17, 2024.</p> <p>R2's electronic medical record included a service plan, last revised November 11, 2024. The service plan lacked a signature or other authentication by the resident, documenting agreement on the services to be provided.</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01640	<p>Continued From page 40</p> <p>R3 R3 was admitted for services on March 9, 2015.</p> <p>R3's electronic medical record included a service plan, last revised on December 16, 2024. The service plan lacked a signature or other authentication by the resident, documenting agreement on the services to be provided.</p> <p>On December 20, 2024, at 12:38 p.m., clinical nurse supervisor (CNS)-A stated the nurse completing the service plan with the resident and their representative, should have had the resident sign the service plan, documenting agreement on the services to be provided. CNS-A stated that did not happen for R2 and R3, therefore, he could not provide a signed service plan.</p> <p>The licensee's Contents of Service Plans policy, dated June 19, 2023, indicated all assisted living residents would have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN) and/or other licensed health professional. Services plans and any revisions to the service plan would have a signature or other authentication by the facility and by the resident.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01640		
01700 SS=F	<p>144G.71 Subd. 2 Provision of medication management services</p> <p>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01700	<p>Continued From page 41</p> <p>a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.</p> <p>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for three of three residents (R1, R2, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01700	<p>Continued From page 42</p> <p>or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on December 16, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents.</p> <p>R1 R1's diagnoses included type 2 diabetes and ketoacidosis (serious complication of diabetes).</p> <p>R1's service plan, signed by R1 on December 6, 2024, indicated R1 received assistance with managing transportation, bathing, medication management, safety checks every shift, monthly vitals, fall interventions, and assistance with insulin and blood sugar checks.</p> <p>On December 18, 2024, at 4:27 p.m., with permission from R1, the surveyor observed while unlicensed personnel (ULP)-F checked R1's blood sugar.</p> <p>R1's MN (Minnesota) - Senior Living - Level of Care and Service Plan, dated December 3, 2024, identified as 90 day assessment, under section titled Medications & Treatments Management, indicated R1 required assistance with medication management, administration by staff three times daily, did not require special preparation of medication, received more than 7 medications, required assistance with insulin and blood sugar management with staff administration of insulin four times daily, blood sugar checks three times daily, required assistance one time daily for scheduled treatments, and needed assistance for ordering medications once monthly.</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01700	<p>Continued From page 43</p> <p>R1's MN-Individualized Medication Management Plan, dated June 12, 2024, indicated medication administration would be provided by facility staff and documentation of administration would be found on the electronic medication record, R1's medications were stored in a locked medication cart and locked medication room, all routes of medications could be delegated to ULP, the facility was responsible for all medication supply monitoring and refills, and the ULP would contact the RN 24 hours per day/7 days per week with any questions, clarification and concerns with medication administration.</p> <p>R1's Order Summary Report, dated February 12, 2024, indicated R1 took medications including a medication for high blood pressure, long acting insulin, short acting insulin, medication for overactive bladder, high cholesterol, vitamin supplement, and an inhaler.</p> <p>R1's record lacked evidence the RN had conducted a medication assessment to include:</p> <ul style="list-style-type: none"> - side effects; - contraindications; - allergic or adverse reactions, and actions to address these issues; and - identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. <p>R2 R2's diagnoses included acute pain, subdural hemorrhage (brain bleed), dementia, psychotic</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01700	<p>Continued From page 44</p> <p>disturbance, mood disturbance, and anxiety.</p> <p>R2's unsigned service plan, last revised November 11, 2024, indicated R2 received services including incontinence care, pain management, safety checks, fall management, assistance with bathing, housekeeping, medication management and administration, dressing, laundry, meal assistance, personal hygiene, mobility, hearing, vision, and transferring.</p> <p>On December 17, 2024, at 12:30 p.m., the surveyor observed R2 sitting at the dining room table waiting for her lunch.</p> <p>R2's MN - Senior Living - Level of Care and Service Plan, dated October 17, 2024, identified as admission assessment, indicated under Medications & Treatments Management, R1 required assistance with medication management, assistance of staff for administration twice daily, no special preparation of medication, received more than 7 medications, and required assistance with ordering medications as needed.</p> <p>R2's MN - Individualized Medication Management Plan, dated October 17, 2024, indicated medication administration would be provided by facility staff, medications were stored in locked medication cart and locked medication room, all routes of medications could be delegated to ULP, the facility was responsible for all medication supply monitoring and refills, and the ULP would contact the RN 24 hours per day/7 days per week with any questions, clarification and concerns with medication administration.</p> <p>R2's Discharge Orders, dated October 17, 2024,</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01700	<p>Continued From page 45</p> <p>indicated R2's medications included mild pain reliever, heart medication, antidepressant, medication to control seizures, and a sleep aid.</p> <p>R2's record lacked evidence the RN had conducted a medication assessment to include:</p> <ul style="list-style-type: none"> - side effects; - contraindications; - allergic or adverse reactions, and actions to address these issues; and - identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. <p>R3</p> <p>R3's diagnoses included Alzheimer's disease with behavioral disturbance, depressive episodes, and high blood pressure.</p> <p>R3's unsigned service plan, last revised December 16, 2024, indicated R3 required assistance with toileting, behavior management, monthly vitals, escorts to and assistance with activities, hourly safety checks, fall interventions, turning and repositioning, pain management, bathing, cognition, housekeeping, medication management, dressing, laundry, meals, personal hygiene, mobility, and transferring.</p> <p>On December 17, 2024, at 12:27 p.m., the surveyor observed while R3 was pushed to the dining room table in her geriatric chair by an unidentified ULP, and ULP-F placed a clothing protector on R3 and announced that it was time to eat.</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01700	<p>Continued From page 46</p> <p>R3's MN - Senior Living - Level of Care and Service Plan, dated August 6, 2024, identified as 90 day assessment, indicated under Medications & Treatments Management, R3 required assistance with medication management with administration four times daily, required special preparation of medications, received more than 7 medications, required assistance with scheduled treatments twice daily, and required assistance to order medications monthly.</p> <p>R3's MN - Individualized Medication Management Plan, dated July 9, 2024, indicated medication administration would be provided by facility staff, medications were stored in locked medication cart and locked medication room, oral medications and eye drops could be delegated to ULP, the facility was responsible for all medication supply monitoring and refills, and the ULP would contact the RN 24 hours per day/7 days per week with any questions, clarification and concerns with medication administration.</p> <p>R3's Clinical Physician Orders, printed December 18, 2024, indicated R3's medications included mild pain reliever, antipsychotic, antidepressant, antianxiety, and severe pain reliever.</p> <p>R3's record lacked evidence the RN had conducted a medication assessment to include:</p> <ul style="list-style-type: none"> - side effects; - contraindications; - allergic or adverse reactions, and actions to address these issues; and - identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives 	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01700	<p>Continued From page 47</p> <p>on interventions to manage the resident's medications and prevent diversion of medications.</p> <p>On December 20, 2024, at 12:38 p.m., CNS-A stated the comprehensive assessment did not include evidence of medication assessment that include the above contents.</p> <p>The licensee's medication management assessment policy, incorrectly titled Director of Wellness, Licensed Health Professionals, ULPs, dated June 19, 2023, indicated a medication management assessment would be completed by a registered nurse during the preadmission assessment, quarterly, with significant change, or as needed. The RN medication management assessment would be completed face-to-face, and would include the following:</p> <ul style="list-style-type: none"> - identification of all known medications, supplements, and herbal remedies the resident was currently taking; - review of medication side effects, contraindications, allergic or adverse reactions; - interventions designed to address any side effects, contraindications, allergies, or adverse reactions; - interventions to prevent medication diversion; and - provide instructions to the resident and any legal or designated representatives on interventions to prevent diversion of medications. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01770	Continued From page 48	01770		
01770 SS=F	<p>144G.71 Subd. 9 Documentation of medication setup</p> <p>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (R10).</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>During the entrance conference on December 16, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents, which included medication setup by the licensed nurse, for one resident (R10), into a medication planner box (a plastic medication box with designated compartments for days and times) for later administration by unlicensed personnel (ULP).</p> <p>R10 R10's diagnoses included Parkinson's disease, bilateral cataracts, and progressive loss of near</p>	01770		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01770	<p>Continued From page 49</p> <p>focusing ability of the eye due to aging.</p> <p>R10's unsigned service plan, last revised December 16, 2024, indicated R10 received medications from the Veterans Administration (VA) and required medication management services to include assistance with administration, ordering of medications, communication with pharmacy, and laboratory appointments. The service plan did not indicate medication setup.</p> <p>R10's MN (Minnesota) - Individualized Medication Management Plan, dated August 30, 2024, indicated R10 required medication management services including medication administration by facility staff, medication administration documentation would be verified on the Electronic Medication Record, the medication administration record (MAR) would be updated with changes, R10 was unable to self-store medications, medications were stored in a locked medication cart and locked medication room, oral medications would be delegated to ULP, licensee was responsible for all medication supply monitoring and refills, and ULP would contact RN 24 hours per day/7 days per week with questions, clarification and concerns with medication administration. The plan did not indicate medication setup.</p> <p>On December 18, 2024, at 4:51 p.m., the surveyor observed while licensed practical nurse (LPN)-K used hand sanitizer and prepared to complete medication setup for R10. R10's medication bottles were in a large cardboard box that LPN-K stated was locked in the medication cart in the medication room. LPN-K stated R10's medications came from the VA and the nurses set them up into medication planner for the ULPs to administer, and they documented on the MAR</p>	01770		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

01770	<p>Continued From page 50</p> <p>after administering. LPN-K set up the following medications into the medication planner:</p> <ul style="list-style-type: none"> - atorvastatin (reduces cholesterol) 10 mg (milligrams) one tablet daily, every morning (AM); - clopidogrel (prevents blood clots) 75 mg one tablet daily, AM; - daily vitamin 400 mcg (micrograms) one tablet daily, AM; - finasteride (treats hair loss/enlarged prostate) 5 mg one tablet daily, AM; - fish oil omega-3 (supplement) 1200 mg one tablet daily, AM; - gabapentin (treats nerve pain) 300 mg two capsules in AM, one capsule in evening (PM); - tolterodine tartrate (treats overactive bladder) 1 mg one tablet twice daily, AM & PM; - tamsulosin hydrochloride (helps with urination) 0.4 mg one tablet daily, AM; - vitamin C (supplement) 500 mg one tablet daily, AM; - vitamin D3 (supplement) 125 mcg one daily, AM; - entacapone (treats Parkinson's disease) 200 mg 1/2 tablet twice daily, AM & P M; and - iron ferrous sulfite (supplement) 325 mg one twice daily, AM & PM. <p>R10's MAR, dated December 1, 2024, through December 31, 2024, included the above medications.</p> <p>R10's record lacked documentation by the licensed nurse at the time of medication setup to include the date of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of the person completing medication setup.</p> <p>On December 18, 2024, at 5:08 p.m., LPN-K stated the ULPs document when the medications</p>	01770		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01770	<p>Continued From page 51</p> <p>were administered but he doesn't document the medication setup anywhere.</p> <p>On December 18, 2024, at 5:15 p.m., CNS-A stated he was unaware of the requirement to document medication setup.</p> <p>The licensee's Documentation of Medication, Treatment, and Therapy Management Services, dated June 19, 2023, lacked direction to document medication setup.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01770		
01790 SS=F	<p>144G.71 Subd. 10 Medication management for residents who will</p> <p>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;</p> <p>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and</p> <p>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.</p> <p>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:</p> <p>(1) the registered nurse has trained the</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01790	<p>Continued From page 52</p> <p>unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and</p> <p>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:</p> <p>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;</p> <p>(ii) how the container or containers must be labeled;</p> <p>(iii) written information about the medications to be provided;</p> <p>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;</p> <p>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;</p> <p>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and</p> <p>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.</p>	01790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

01790	<p>Continued From page 53</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available.</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 the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on December 16, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents.</p> <p>The licensee's Delegation of Medications to be Given by Unlicensed Staff for Residents Time Away from Home policy, dated June 19, 2023, noted the licensee would provide the necessary medications, education, instructions and support to meet the resident's medication needs when they are away from home if the facility provides assistance with self-administration of medication, administration, administration or storage of medications. Only unlicensed staff that have been trained and have demonstrated competency would be assigned to provide the medication for an unplanned leave of absence not to exceed 7</p>	01790		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01790	Continued From page 54 days of medications. The policy lacked the following required content: - a review by the RN of the completion of the task to verify it was completed accurately by the ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01940	<p>Continued From page 55</p> <p>possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1).</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>Findings include:</p> <p>During the entrance conference on December 16, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment and therapy management services to the licensee's residents, including oxygen, compression stockings, modified diets, orthotic braces, and blood glucose checks.</p> <p>R1's diagnoses included type 2 diabetes and ketoacidosis (serious complication of diabetes).</p> <p>R1's service plan, signed by R1 on December 6, 2024, indicated R1 received assistance with managing transportation, bathing, medication management, safety checks every shift, monthly</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01940	<p>Continued From page 56</p> <p>vitals, fall interventions, and assistance with insulin and blood sugar checks.</p> <p>On December 18, 2024, at 4:27 p.m., with permission from R1, the surveyor observed while unlicensed personnel (ULP)-F checked R1's blood sugar.</p> <p>R1's Order Summary Report, dated February 12, 2024, included, "Blood Sugars four times a day for DM 2 [diabetes mellitus type 2] Call MD [medical doctor]/NP [nurse practitioner] for BG [blood glucose] <75 MG [milligrams]/DL [deciliter] OR BG > 400."</p> <p>R1's Medication Administration Record (MAR), dated December 1, 2024, through December 31, 2024, indicated, "Check Blood sugar before meals." Documentation indicated blood sugars were checked three times daily at 7:30 a.m., 11:30 a.m., and 5:00 p.m., not four times daily as ordered.</p> <p>R1's electronic record did not include an electronic treatment administration record.</p> <p>R1's MN- Individualized Treatment and Therapy Management Plan, dated June 12, 2024, under "1. Type of ordered/prescribed services that will be provided to the resident and delegated to ULP [unlicensed personnel]," indicated occupational and physical therapy. Blood glucose monitoring was not checked as a service that would be provided and delegated to the ULP. The plan also indicated a registered nurse (RN) was available in-person or by phone 24/7 to report problems, concerns and clarification with treatment/therapy services, documentation and instructions of the treatment/therapy, and verification that treatment and therapy was administered could be found on</p>	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

01940	<p>Continued From page 57</p> <p>the electronic health record (EHR)/electronic treatment administration record (eTAR), and updates/changes to the treatment/therapy plan and monitoring to prevent possible complications and adverse reaction could be found on the EHR/eTAR.</p> <p>R1's record lacked an individualized treatment and therapy management plan to include the following required content:</p> <ul style="list-style-type: none"> - a statement of the type of service that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; and - identification of treatment or therapy tasks that would be delegated to unlicensed personnel. <p>On December 20, 2024, at 11:30 a.m., CNS-A stated R1's treatment and therapy management plan did not include all of the required content and stated he needed to clarify the provider's order for blood sugar testing due to the discrepancy.</p> <p>The licensee's Individualized Medication, Treatment, & Therapy Management Plans policy, dated June 19, 2023, indicated the RN would develop a treatment and/or therapy management plan based on the resident assessment and the services provided. The policy directed the treatment and therapy management plan would include:</p> <ul style="list-style-type: none"> - a statement of the type of service(s) provided; - documentation of specific resident instructions relating to the treatments and/or therapy administration; - identification of treatment or therapy tasks that may be delegated to unlicensed staff member; - procedures for notifying a registered nurse or appropriate licensed health professional when a 	01940		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01940	<p>Continued From page 58</p> <p>problem arises with treatments and/or therapy services; - resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment and/or therapy to prevent possible complications or adverse reactions.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01940		
01960 SS=D	<p>144G.72 Subd. 5 Documentation of administration of treatments</p> <p>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as ordered, or to document the reason they were not administered as ordered, and any follow up procedures that were provided to meet the resident's needs, for one of one resident (R1) receiving blood glucose monitoring.</p>	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01960	<p>Continued From page 59</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>During the entrance conference on December 16, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment and therapy management services to the licensee's residents, including oxygen, compression stockings, modified diets, orthotic braces, and blood glucose checks.</p> <p>R1's diagnoses included type 2 diabetes and ketoacidosis (serious complication of diabetes).</p> <p>R1's service plan, signed by R1 on December 6, 2024, indicated R1 received assistance with managing transportation, bathing, medication management, safety checks every shift, monthly vitals, fall interventions, and assistance with insulin and blood sugar checks.</p> <p>On December 18, 2024, at 4:27 p.m., with permission from R1, the surveyor observed while unlicensed personnel (ULP)-F checked R1's blood sugar.</p> <p>R1's Order Summary Report, dated February 12, 2024, included, "Blood Sugars four times a day for DM 2 [diabetes mellitus type 2] Call MD [medical doctor]/NP [nurse practitioner] for BG</p>	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
01960	<p>Continued From page 60</p> <p>[blood glucose] <75 MG [milligrams]/DL [deciliter] OR BG > 400."</p> <p>R1's Medication Administration Record (MAR), dated December 1, 2024, through December 31, 2024, indicated, "Check Blood sugar before meals." Documentation indicated blood sugars were checked three times daily at 7:30 a.m., 11:30 a.m., and 5:00 p.m., not four times daily as ordered.</p> <p>On December 20, 2024, at 11:30 a.m., CNS-A stated he could not explain why R1's orders directed blood sugar testing four times daily but were being completed three times daily. CNS-A stated he needed to clarify the provider's order due to the discrepancy.</p> <p>The licensee's Medication & Treatment Orders: Receiving, Renewal, Implementation, and Reordering policy, dated June 19, 2023, indicated a licensed nurse or other individual qualified to receive orders would obtain medication and treatment orders, and would reconcile medications and treatments.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01960		
02110 SS=F	<p>144G.82 Subd. 3 Policies</p> <p>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:</p> <p>(1) philosophy of how services are provided</p>	02110		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

02110	<p>Continued From page 61</p> <p>based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;</p> <p>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;</p> <p>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;</p> <p>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;</p> <p>(5) staff training specific to dementia care;</p> <p>(6) description of life enrichment programs and how activities are implemented;</p> <p>(7) description of family support programs and efforts to keep the family engaged;</p> <p>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;</p> <p>(9) transportation coordination and assistance to and from outside medical appointments; and</p> <p>(10) safekeeping of residents' possessions.</p> <p>(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents with dementia</p>	02110		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
02110	<p>Continued From page 62</p> <p>care.</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 is 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>The licensee held an assisted living with dementia care license through August 31, 2025, and was licensed for a bed capacity of 80 residents.</p> <p>On December 19, 2024, at 2:46 p.m., licensed assisted living director (LALD)-B provided the licensee's Disclosure of Special Care Status and Dementia Care Training. The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in, as required, including:</p> <ul style="list-style-type: none"> - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - description of family support programs and 	02110		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

02110	<p>Continued From page 63</p> <p>efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions.</p> <p>On December 19, 2024, at 2:46 p.m., via telephone interview, LALD-B stated the licensee was not currently providing the required policies to the resident and/or the residents legal/designated representative at the time of move-in.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	02110		
02310 SS=I	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for three of three residents (R5, R8, R9) with an assistive device. This resulted in an immediate order for correction on December 18, 2024.</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

02310	<p>Continued From page 64</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>During the entrance conference on December 16, 2024, at 10:45 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A provided a current resident roster. On December 17, 2024, at 10:40 a.m., the surveyor requested CNS-A update the roster to indicate all residents in the facility with bedrails. At 12:30 p.m., CNS-A provided the updated resident roster, and stated the roster now included all residents with bedrails.</p> <p>R5 During a visit to R5's apartment with unlicensed personnel (ULP)-F on December 17, 2024, at 12:10 p.m., the surveyor observed R5's bed to have bilateral consumer bedrails, attached to the bed frame of the twin-sized bed. The left bedrail was very loose and could be easily moved back and forth. The bedrails had no identifying information of the manufacturer, were square, with seven open areas. ULP-F stated R5 was transferred from the bed to the wheelchair with a full body lift, so stated she didn't use the bedrails for transferring; however, stated R5 used the bedrails to turn from side to side in the bed.</p> <p>R5 was admitted to the facility on March 21, 2023, with diagnoses including dementia,</p>	02310		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	<p>Continued From page 65</p> <p>psychotic disturbance, mood disturbance and anxiety.</p> <p>R5's MN (Minnesota) - Senior Living - Level of Care and Service Plan, dated August 28, 2024, indicated R5 resided in the Memory Care unit, and received services including monthly vital signs, meal and activity escort, meals, skin monitoring, turning and repositioning, medication management, weekly bathing assistance, toileting and incontinence care, assistance with dressing, oral hygiene, nail care, foot care, mobility and transfer assistance, safety checks, housekeeping and laundry.</p> <p>On December 17, 2024, at 2:16 p.m., CNS-A stated the resident roster did not indicate that R5's bed had consumer bedrails, because he was not aware of the bedrails. CNS-A stated R5 was admitted recently to Hospice and stated they probably put them on the bed, and then corrected himself and stated R5 was admitted to Hospice "a while ago." CNS-A stated the nurse assigned to the dementia care unit was responsible for completing resident assessments, including the device assessment for the bedrails, and maintenance manager (MM)-C and director of resident relations (DRR)-E were responsible for measuring the devices. CNS-A searched in R5's electronic record in the presence of the surveyor, and stated he did not see a device assessment for R5's bedrails. At 2:36 p.m., CNS-A provided a Bed System Measurement Device Test Results Worksheet, dated September 30, 2024, identified only with R5's room number and indicated it was completed by MM-C and DRR-E. The worksheet included a diagram of a bed and included zones 1 (within the bedrail), zone 2 (under the bedrail, between the bedrail supports or next to a single bedrail support), and zone 3 (between the bedrail</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

02310	<p>Continued From page 66</p> <p>and the mattress) with a "P" for pass, and zone 4 (between the bedrail, at the ends of the bedrail) with an "F" for fail. CNS-A stated MM-C and DRR-E completed the form after assessing the bedrails, and indicated R5's bedrails did "not pass." CNS-A stated if MM-C and DRR-E assessed the bedrail to "not pass," the nurse would discuss this with the resident and family, and decide how to proceed. CNS-A stated risks and benefits were discussed, and if a resident chose to keep the bedrails, there would be documentation in the resident's progress notes. CNS-A stated he could not find any documentation in R5's progress notes about the bedrails or documentation that R5 and/or R5's responsible party had been educated on the risk for injury up to and including death due to entrapment, lacked evidence of manufacturer's guidelines for appropriate installation, and had not referred to the Consumer Product Safety Commission (CPSC) for information related to portable bedrail recalls.</p> <p>R8 On December 17, 2024, at 3:21 p.m., the surveyor and LALD-B entered R8's apartment with her permission. R8 was sitting in the recliner. When LALD-B announced the need to look at R8's bed and bedrail, R8 stated, "I don't like you guys," and stated her husband recently passed and he had "built" the bedrail for R8's bed, and she did not want it removed. R8 stated her husband purchased the consumer bedrail and then "modified it," adding more metal pieces to make the device more safe for R8 and to ensure the bedrail met the requirements. The bedrail was slid under the right side of the twin-sized mattress, not attached to the bed frame, and easily slid when pulled. The bedrail had four large openings, and R8's husband riveted a large "V"</p>	02310		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	<p>Continued From page 67</p> <p>shaped metal bar to make the openings smaller so R8 "couldn't get stuck" in the bars. R8 stated, "He even spray painted it." R8 stated she used the bedrail for support when getting in and out of bed.</p> <p>R8 was admitted to the facility on July 21, 2021, with diagnoses including chronic kidney disease and type 2 diabetes.</p> <p>R8's MN - Senior Living - Level of Care and Service Plan, dated December 2, 2024, indicated R8 resided in the Assisted Living Community, and received services including monthly vital signs, meal and activity escort, meals, pain management, skin monitoring, medication management, insulin administration, blood glucose monitoring, twice weekly bathing assistance, toileting assistance, assistance with dressing, nail care, mobility stand by assistance, fall risk management, safety checks, housekeeping and laundry.</p> <p>R8's MN - Device Assessment Tool, dated June 13, 2024, indicated R8 had an upper assist bar/grab bar per resident's request, for positioning and mobility. R8 reported she had used the device without issue and relied on the device to maintain independence. R8 had no detectable cognitive deficits and was able to make needs known, and was continent. R8 had a fall on April 21, 2024, while attempting to sit in recliner, missed the chair and fell to the floor. The assessment indicated the device was not recommended, and noted the licensee recommended the device be removed due to "unsafe placement." Also noted, "Family removed device." The assessment indicated the bedrails did not securely attach to the bed and slid between the mattress and bedframe, posing</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

02310	<p>Continued From page 68</p> <p>increase risk for injury. The safety concerns with the current device were discussed with the resident. The assessment findings included, "The device has been assessed and presents an increase risk for injury due to the design of the device. Risks vs. benefit discussed with resident, and resident agrees to remove rails from bed. Resident agrees that using a walker at bedside provides adequate support to get in and out of bed."</p> <p>R8's Bed System Measurement Device Test Results Worksheet, dated August 30, 2024, identified with only R8's previous room number, and completed by MM-C and DRR-E, indicated zones 1, 3, and 4 passed and zone 2 failed.</p> <p>R8's progress notes, dated June 17, 2024, at 10:11 a.m., noted, "New order for Halo [type of assistive device] Grab bar." Review of the progress notes through December 17, 2024, lacked any further information on bedrails.</p> <p>On December 18, 2024, at 7:45 a.m., DRR-E stated the licensee implemented the bedrail assessment and stated they have a very expensive tool to determine if a bedrail was safe. DRR-E stated the tool doesn't do actual measurements; however, the tool has red on one end and green on the other and when they hold it up to the zone they are measuring, if it shows green, it passes, if it shows red, it fails. If one zone fails, "the bedrail fails." DRR-E stated, at first, if a bedrail failed the test, he was directed to remove the bedrail. Then, he was told that he shouldn't remove the bedrail if the resident wanted to keep it, but was directed to discuss the risks of using the bedrail. DRR-E stated when R8's bedrail was accessed, the bedrail did not pass, so after discussion with R8 and her</p>	02310		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	<p>Continued From page 69</p> <p>husband, they agreed to remove the bedrail. An order was received for a Halo device, but when R8 learned that Hospice would not provide the device, R8's husband "modified" the current bedrail to ensure R8's safety.</p> <p>R8's record lacked documentation that R8 and/or R8's responsible party had been educated on the risk for injury up to and including death due to entrapment, lacked evidence of manufacturer's guidelines for appropriate installation, and had not referred to the Consumer Product Safety Commission (CPSC) for information related to portable bedrail recalls.</p> <p>R9 On December 17, 2024, at 3:28 p.m., the surveyor and LALD-B entered R9's apartment. R9 was not present. R9's bed had bilateral assistive devices, identified by LALD-B as "Halos [type of assistive device]." The devices were circular with seven openings and were securely attached to the bedrail.</p> <p>R9 was admitted to the facility on June 25, 2020, with diagnoses including chronic obstructive pulmonary disease with dependence on oxygen.</p> <p>R9's MN - Senior Living - Level of Care and Service Plan, dated December 3, 2024, indicated R9 resided in the Assisted Living Community with Hospice services, and received services including monthly vital signs, oxygen reminders, meals, skin monitoring, medication management, weekly bathing assistance, assistance with dressing, oral care, fall risk management, safety checks, housekeeping and laundry.</p> <p>R9's Bed System Measurement Device Test Results Worksheet, dated October 28, 2024,</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	<p>Continued From page 70</p> <p>identified with only R9's room number, and completed by MM-C and DRR-E, indicated zones 1 and 3 passed and zone 2 and 4 failed.</p> <p>On December 17, 2024, at 3:40 p.m., CNS-A searched in R9's electronic record in the presence of the surveyor, and stated he did not see a device assessment for R9's bedrails.</p> <p>On December 18, 2024, at 7:20 a.m., R9's record included MN - Device Assessment Tool, initiated December 2, 2024, signed and completed on December 17, 2024, at 4:38 p.m. The assessment indicated R9 had bilateral Halo devices per resident request, and noted R9 used them to assist with getting in and out of bed. R9 was able to make needs known and was oriented. R9 was ambulatory, continent, device was not a restraint, and noted the device was recommended. The assessment findings indicated the bedrails were attached to the bed per manufacturer's guidelines; however, noted the bedrails still presented an increased risk for entrapment based on assessment findings, including gaps in bedrails/mattress. Risk vs benefit were discussed with the resident.</p> <p>On December 18, 2024, at 8:09 a.m., CNS-A stated R9's bedrail assessment was done on December 2, 2024, but wasn't signed and closed until December 17, 2024, when he realized it wasn't signed.</p> <p>Review of R9's progress notes lacked any mention of R9's bedrails.</p> <p>R9's record lacked documentation that R9 and/or R9's responsible party had been educated on the risk for injury up to and including death due to entrapment, lacked evidence of manufacturer's</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	<p>Continued From page 71</p> <p>guidelines for appropriate installation, and had not referred to the Consumer Product Safety Commission (CPSC) for information related to portable bedrail recalls.</p> <p>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated "licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information."</p> <p>The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: IMMEDIATE</p>	02310		
02350 SS=D	<p>144G.91 Subd. 7 Courteous treatment</p> <p>Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect</p>	02350		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

02350	<p>Continued From page 72</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident (R6) was treated with dignity and respect.</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>R6's diagnoses included dementia with behavioral disturbance, anxiety disorder, insomnia, and aphasia (communication disorder affecting ability to speak and understand what is being said).</p> <p>R6's service plan, last revised December 16, 2024, indicated R6 received services including assistance with bowel and bladder incontinence, with toileting, peri care and care with all incontinent episodes and linen changes related to incontinence as needed. The service plan also indicated R6 required housekeeping with linen changes and laundry weekly and as needed.</p> <p>On December 18, 2024, at 10:12 a.m., with R6's permission, the surveyor entered R6's room with unlicensed personnel (ULP)-G. R6 was partially sitting up in her bed and stated "yes" when ULP-G asked if she was ready to get up for the</p>	02350		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31334	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
--	---

(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
--------------------	--	---------------	---	--------------------

02350	<p>Continued From page 73</p> <p>day. The surveyor observed while ULP-G performed personal cares and transferred R6 from the bed to the toilet with a sit-to-stand lift and ULP-H's assistance, and then from the toilet with the sit-to-stand lift, into the wheelchair, with registered nurse (RN)-J and ULP-H's assistance. ULP-G straightened R6's bathroom, putting items away, combed R6's hair, and pulled R6's blanket over a visibly soiled mattress pad on the bed. When the surveyor asked why R6 was sleeping on only a mattress pad with no sheets on her bed, ULP-G shrugged her shoulders, pulled the blanket back, pulled the soiled mattress pad off the bed, and reached on top of the portable closet in R6's room to grab an unfolded top sheet out of a pile of unfolded laundry. ULP-G put the top sheet on the bare mattress and tucked it in as a bottom sheet, placed an incontinence pad on top of the sheet, and covered with R6's blanket. ULP-G removed the pillowcase, reached on top of the portable closet to grab an unfolded pillowcase, put the pillowcase on the pillow, and placed it on the bed.</p> <p>On December 18, 2024, at 5:15 p.m., clinical nurse supervisor (CNS)-A stated he wasn't sure why R6 was sleeping on a soiled mattress pad, with no bed linens on her bed. CNS-A stated the licensee had extra sheets if R6's sheets were being laundered and residents should never have to sleep on a mattress pad. CNS-A stated, "It's not dignified."</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	02350		
-------	---	-------	--	--



Type: Full
Date: 12/17/24
Time: 16:00:00
Report: 8087241284

Food and Beverage Establishment Inspection Report

Location:

Stoney River Ramsey
14401 Nowthen Boulevard Nw
Ramsey, MN55303
Anoka County, 02

Establishment Info:

ID #: 0039421
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126159936
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -10 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: BEEF STROGY
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: HB EGG
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Type: Full
Date: 12/17/24
Time: 16:00:00
Report: 8087241284
Stoney River Ramsey

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: KITCHEN STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 38 Degrees Fahrenheit - Location: KITCHEN STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: GROUND BEEF
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN STAND-UP COOLER
Violation Issued: No

Process/Item: Hot Holding: GOOLASH
Temperature: 149 Degrees Fahrenheit - Location: SERVICE LINE WARMING WELL
Violation Issued: No

Process/Item: Cold Holding: CUT TOMATO
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: EXPO AREA STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 41 Degrees Fahrenheit - Location: EXPO AREA STAND-UP COOLER
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	0

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER TONY ZAMORA.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

- HAND WASHING
- NOROVIRUS
- BARE HAND CONTACT WITH READY TO EAT FOODS
- EMPLOYEE ILLNESS

Type: Full
Date: 12/17/24
Time: 16:00:00
Report: 8087241284
Stoney River Ramsey

Food and Beverage Establishment Inspection Report

EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND HRD NURSE SURVEYOR LOANNE DEGAGNE.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8087241284 of 12/17/24.

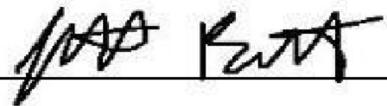
Certified Food Protection Manager: TONY ZAMORA

Certification Number: FM102807 Expires: 03/16/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

TONY ZAMORA
KITCHEN MANAGER

Signed:  _____

John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us