Electronically Delivered
January 21, 2022

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

RE: Project Number(s) SL31334015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 30, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
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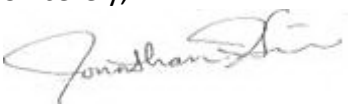
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31334	A. BUILDING: _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY RIVER RAMSEY	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	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. 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. INITIAL COMMENTS: SL31334015 On December 28 through December 30, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were sixty-six (66) residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all sixty-six (66) residents. 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). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report,	0 480		

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0 480	Continued From page 2 dated December 29, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for two of five residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 630		

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0 630	Continued From page 3 The findings include: R1 R1 was admitted to the licensee on April 29, 2021. R1's "resident evaluation" dated December 28, 2021, indicated R1 resided on the memory care unit and required assistance with meals, grooming, bathing, and medications. R1's record included a vulnerability assessment dated May 19, 2021, that identified R1's vulnerabilities as confusion, hearing difficulties, speech barriers, and inability to report maltreatment. R1's record included an incident report dated May 12, 2021, that indicated R1 lost her balance and fell. R1's record included an incident report dated May 14, 2021, that indicated R1 attempted to hit another resident and later lost her balance and fell as she walked away. R1's record included an incident report dated July 14, 2021, that indicated R1 threatened a visitor. R1's record included an incident report dated September 11, 2021, that indicated R1 was found lying on the floor. R1's recorded included an incident report dated October 9, 2021, that indicated R1 took a bite out of a bar of soap. R1's IAPP did not reflect vulnerabilities as	0 630		

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0 630	Continued From page 4 identified in the incident reports and did not include interventions to support R1 with identified vulnerabilities. On December 29, 2021, at approximately 12:25 p.m., RN-A verified R1's IAPP was not updated to reflect R1's current vulnerabilities with the interventions to address those vulnerabilities after the incidents that occurred from May to October 2021. R3 R3 was admitted to the licensee on January 24, 2020. R3's "resident evaluation" dated August 25, 2021, indicated R3 needed assistance with medication management and laundry. R3's service plan dated December 28, 2021, indicated R3 received services for assistance with medication administration, housekeeping and laundry. R3's record included a vulnerability assessment dated December 28, 2021 (during the survey period), identified R3's vulnerabilities, which included a history of falls and the need for assistance with financial management. R3's record lacked an IAPP created upon admission or prior to the survey. On December 29, 2021, at 3:57 p.m., RN-A stated R3 did not have a previous IAPP that RN-A could find in R3's record. RN-A indicated R3 was independent upon admission to the facility, but began receiving assistance with medication management during August 2021.	0 630		

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0 630	Continued From page 5 A policy regarding resident IAPPs was requested, but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c 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: (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. 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 information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and by not posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all sixty-six (66) residents, staff, and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 6 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). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. In addition, there were no postings containing information or the reporting number for the MAARC. On December 30, 2021, at approximately 8:45 a.m., the surveyor observed the facility's common areas and noted no postings with 911 emergency number or information related to reporting suspected maltreatment to MAARC. During an interview on December 30, 2021, at approximately 8:45 a.m., the licensed assisted living director (LALD)-B verified the required information regarding 911 emergency number and MAARC reporting number was not posted in the common areas of the facility. A policy regarding posting suspected maltreatment reporting and 911 emergency numbers was requested, but not provided. The licensee's Abuse, Neglect and Exploitation policy dated November 1, 2021, did not include requirements for posting information about suspected maltreatment or 911 emergency numbers.	0 640		

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0 640	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and history and symptom screening for two of two employees (registered nurse (RN)-A, and unlicensed personnel (ULP)-C) with employee records reviewed.	0 660		

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0 660	Continued From page 8 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). The findings include: The facility TB risk assessment dated August 1, 2021, indicated the facility was a low risk setting for TB transmission. RN-A was hired June 28, 2021, and provided direct cares for residents of the facility. RN-A's employee file lacked documentation of RN-A's TB history and symptom screening form. RN-A's employee file lacked documentation verifying RN-A completed a TB test. During an interview on December 28, 2021, at 3:20 p.m., licensed assisted living director (LALD)-B acknowledged RN-A's employment record lacked documentation of a TB history and symptom screening form and TB test. During an interview on December 28, 2021, at 2:04 p.m., RN-A verified her file lacked documentation of a TB history, TB symptom screening form, and a completed TB test. RN-A stated she did not complete a TB test upon hire. RN-A stated she completed a TB test for a previous employer six months prior to her hire with the licensee. RN-A produced a copy of a T-Spot blood test dated January 11, 2021. RN-A acknowledged that the T-Spot Blood test was not	0 660		

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0 660	Continued From page 9 completed within 90 days of hire date. ULP-C was hired December 15, 2020, and provided direct cares for residents of the facility. ULP-C's employee file contained a TB history and symptom screening form from a previous employer dated November 11, 2020. ULP-C's employee file also contained documentation of a single step TB skin test dated November 11, 2020 (within 90 days of hire). During an interview on December 28, 2021, at 3:10 p.m., LALD-B acknowledged ULP-C's employment record contained a TB history and symptom screening form from a previous employer and did not contain verification of a second TB skin test. During an interview on December 29, 2021, at 10:10 a.m., RN-A verified ULP-C did not have a second TB skin test. RN-A stated no TB screening form was completed for ULP-C upon hire. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test.	0 660		

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0 660	Continued From page 10 The licensee's Tuberculosis Screening policy dated July 22, 2021, indicated new staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs, and have a blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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	0 810		

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0 810	Continued From page 11 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees 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. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan and required evacuation drills. In addition, the licensee documentation failed to show the minimum required training frequency on evacuations for employees and residents. This has the potential to directly affect the safety of all residents receiving assisted living services, staff, and visitors. 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). The findings include: On December 28, 2021, at approximately 3:40 p.m., survey staff received the facility fire safety and evacuation plan documentation, drills, and training records from the licensed assisted living director (LALD)-B for review. The documentation	0 810		

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STONEY RIVER RAMSEY	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	Continued From page 12 showed the following: 1. The faciltiy fire safety and evacuation plan documentation lacked the specific procedures for employee actions to be taken in the event of a fire and fire protection procedures necessary for addressing all residents including any unique resident-specific situations during an evacuation such as residents who may be wheelchair-bound, on walkers, bedridden, and needing assistance during an evacuation. Fire safety and evacuation plan must specifically address procedures for assisted living residents with dementia care during an evacuation. 2. The documentation lacked the required training at a minimum frequency of twice a year for employees after hiring on the facility fire safety and evacuation plan. The facility's form, Emergency Preparedness Onboarding and Annual Refresher Training (undated), revealed that training including fire emergency and evacuation were being provided to employees upon onboarding related annual refresher training, and did not meet the required minimum frequency. 3. The documentation lacked the content of required annual training of residents that can self-assist in their evacuation on the proper actions to be taken in the event of a fire, including movement, evacuation, or relocation. The licensee's form, Resident Emergency Preparedness Training, undated, including evacuation, revealed that training was provided to residents upon 24 hours of resident move in, but lacked specific content on the required annual training of residents. 4. An insufficient number of evacuation drills were performed by the employees. Records showed the last evacuation drills were performed on October 18, 2021, at 4:30 p.m. and on October 19, 2021, at 6:50 p.m. Evacuation drills must be	0 810		

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0 810	Continued From page 13 performed by employees twice per year per shift, with at least one evacuation drill every other month. During an interview on December 28, 2021, at approximately 5:00 p.m., the LALD-B acknowledged the surveyor's findings. The LALD-B further clarified the facility had a evacuation drill scheduled for the following week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (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,	01470		

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01470	Continued From page 14 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 employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to all required assisted living regulation content for two of two employees	01470		

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01470	Continued From page 15 (registered nurse (RN)-A, unlicensed personnel (ULP)-C) with records reviewed. 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). The findings include: RN-A was hired June 28, 2021, and provided supervision and direct cares for the residents of the facility. RN-A's employee record lacked documentation that the following orientation topics were completed: - Overview of Assisted Living statutes; - Handling of emergencies and use of emergency services; - 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; -Provider's scope of license and types of assisted living services the employee will provide; and - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 29, 2021, at 11:35 a.m., RN-A acknowledged the orientation record lacked the	01470		

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01470	Continued From page 16 required topics listed above. On December 29, 2021, at 12:15 p.m., licensed assisted living director (LALD)-B verified RN-A's orientation record did not include the above listed topics. ULP-C was hired December 15, 2020, and provided direct cares for the residents of the facility. ULP-C's record included documentation of orientation completed December 26 to 30, 2020, and updated orientation completed October 25 to 28, 2021, but lacked documentation the following orientation topics were completed: -Introduction and review of the facility's policies and procedures; -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 -Provider's scope of license and types of assisted living services the employee will provide. On December 29, 2021, at 8:57 a.m., LALD-B acknowledged the orientation record for ULP-C was missing the above topics. The licensee's Orientation for Home Care Staff policy dated July 14, 2017, indicated, "All staff of [licensee] providing and supervising direct home care services must complete an orientation to home care licensing requirements and regulations before providing home care services to clients. All staff must be trained and competent in the provision of home care services consistent	01470		

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01470	Continued From page 17 with current practice standards and appropriate to client needs." The policy lacked current assisted living orientation requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to each resident for one of two employees (unlicensed personnel (ULP)-C) with employee records reviewed. 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). The findings include:	01480		

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01480	Continued From page 18 ULP-C was hired December 15, 2020, to provide direct cares to the residents of the facility. ULP-C's employee record included documentation of orientation completed December 26 to 30, 2020, and updated orientation completed October 25 to 28, 2021. ULP-C's employee record lacked documentation of ULP-C's orientation to individual residents of the facility. During an interview on December 29, 2021, at 8:57 a.m., the licensed assisted living director (LALD)-B verified there was no documentation of orientation to residents in ULP-C's employee record. During an interview on December 29, 2021, at 2:15 p.m., registered nurse (RN)-A stated "face-to-face" orientation to residents occurred during orientation "shadow" period (when a new ULP would work with an existing employee). RN-A verified there was no documentation of the orientation to residents for ULP-C. The licensee's Initiation of Services policy dated July 14, 2021, indicated before initiating delegated nursing services by unlicensed personnel, a RN must orient each person who will perform services to the resident and the care services to be performed. The policy further indicated the orientation must be documented and kept in the employees file. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01480		

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01620	Continued From page 19	01620		
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (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 resident and cannot exceed 90 calendar days from the last date of the assessment. (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. (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. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for four of five residents (R1, R2, R3, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 20	01620		

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).

The findings include:

R1
R1 was admitted April 29, 2021, and had diagnoses to include dementia and hypertension.

R1's record included documentation of a comprehensive nursing assessment completed May 19, 2021, and a reassessment completed December 28, 2021, during the survey time and greater than 90 days after the previous assessment.

During an interview on December 29, 2021, at 1:35 p.m., RN-A verified the comprehensive nursing reassessment was not completed within 90 days after the previous assessment.

R2
R2 was admitted January 24, 2020, and had diagnoses to include hypertension, and diabetes mellitus.

R2's record included documentation of a comprehensive nursing assessment completed June 16, 2021, and a reassessment completed December 28, 2021, during the survey period and greater than 90 days after the previous assessment.

During an interview on December 29, 2021, at 2:03 p.m., RN-A verified R2 had an assessment

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01620	Continued From page 21 completed June 16, 2021, and an assessment started August 16, 2021, but not finalized until December 28, 2021, during the survey. RN-A acknowledged the reassessment for R2 was completed greater than 90 days after the previous assessment. R3 R3 was admitted January 24, 2020, and had diagnoses to include hypertension, and fibromyalgia. R3's record included documentation of a comprehensive nursing assessment completed August 25, 2021, and a reassessment completed December 28, 2021, during the survey period and greater than 90 days after the previous assessment. During an interview on December 29, 2021, at 3:47 p.m., RN-A verified R3's most recent assessment, dated December 28, 2021, was completed greater than 90 days after the previous assessment completed August 25, 2021. R5 R5 was admitted June 30, 2021, and had diagnoses to include depression, diabetes, and hypertension. R5's record included documentation of a comprehensive nursing assessment completed July 22, 2021, and a reassessment completed December 1, 2021, greater than 90 days after the previous assessment. During an interview on December 29, 2021, at 1:35 p.m., RN-A verified R5's comprehensive nursing reassessment was not completed within 90 days of the previous assessment.	01620		

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01620	Continued From page 22 The licensee's Assessment-Schedules policy dated July 14, 2017, indicated "client monitoring and reassessment" would be completed within 14 days of initiation of services and "ongoing client monitoring and reassessment" must be completed at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

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01650	Continued From page 23 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for five of five residents (R1, R2, R3, R4, R5) with records reviewed. 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). The findings include: R1's service plan dated December 28, 2021, indicated R1 received services which included assistance with medication administration, bathing, grooming, and laundry. R2's service plan dated December 29, 2021, indicated R2 received services which included assistance with medication management, laundry and housekeeping. R3's service plan dated December 28, 2021, indicated R3 received services which included assistance with medication management, laundry and housekeeping.	01650		

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01650	Continued From page 24 R4's service plan dated December 28, 2021, indicated R4 received services which included assistance with bathing, grooming, laundry, and medication management. R5's service plan dated December 1, 2021, indicated R5 received services which included assistance with bathing, transfers, and medication management. The service plans for R1, R2, R3, R4 and R5 all lacked the following: - Identification of staff or categories of staff who will provide the service. - The schedule and methods of monitoring assessments of the resident. - The schedule and methods of monitoring staff providing services. - A contingency plan that includes: a. the action to be taken if the scheduled service cannot be provided; b. information and a method to contact the facility; c. the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who had authority to sign for the resident in an emergency; and d. the circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On December 29, 2021, at 2:03 p.m. registered nurse (RN)-A acknowledged the service plans lacked all the required content. RN-A indicated the software used by the licensee did not create	01650		

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01650	Continued From page 25 the service plan to include the required content. The licensee's Service Plan policy dated July 14, 2017, indicated, "All services provided to clients of [licensee] will be delivered after 1) an assessment by an RN is completed and 2) an up-to date Service Plan is signed by an RN and the client or the client's designated representative." The policy further indicated the service plan would include the following: "1. A description of the home care services to be provided, the fees for services (including any changes to the provider's fee for services), and the frequency of each service, according to the client's current review or assessment and client preferences. 2. The identification of the type of staff (RN/LPN, Therapists, Unlicensed Personnel, etc.) that will provide the services. 3. The schedule and methods of monitoring reviews or assessments of the client. 4. The frequency of sessions of supervision of staff and type of personnel who will supervise staff. 5. A contingency plan that includes: a. the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; b. information and method for a client or client's representative to contact the home care provider; c. names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and d. the circumstances in which emergency medical services are not to be summoned	01650		

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01650	Continued From page 26 consistent with chapters 1458 and 145C, and declarations made by the client under those chapters. e. Information regarding how to contact the Minnesota Office of the Ombudsman for Long-Term care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have 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. (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	01700		

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	31334	A. BUILDING: _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY RIVER RAMSEY	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	Continued From page 27 diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for five of five residents (R1, R2, R3, R4, R5) with records reviewed. 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). The findings include: R1 had diagnoses to include dementia and hypertension. R1's "resident evaluation" dated December 28, 2021, indicated R1 received medication management services. R1's Medication Administration Record for December 2021 listed medications, times to administer, and staff initials indicating the medications had been administered. R2 had diagnoses to include hypertension, and diabetes mellitus. R2's "resident evaluation", dated December 29, 2021, indicated R2 received medication management services. R2's Medication Administration Record for December 2021 listed medications, times to administer, and	01700		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	Continued From page 28 staff initials indicating the medications had been administered. R3 had diagnoses to include hypertension, and fibromyalgia. R3's "resident evaluation", dated December 28, 2021, indicated R3 received medication management services. R3's Medication Administration Record for December 2021 listed medications, times to administer, and staff initials indicating the medications had been administered. R4 had diagnoses to include cancer, diabetes, renal disease, and hypertension. R4's "resident evaluation" dated December 22, 2021, indicated R4 received medication management services. R4's Medication Administration Record for December 2021 listed medications, times to administer, and staff initials indicating the medications had been administered. R5 was admitted June 30, 2021, and had diagnoses to include depression, diabetes, and hypertension. R5's "resident evaluation", dated December 1, 2021, indicated R5 received medication management services. R5's Medication Administration Record for December 2021 listed medications, times to administer, and staff initials indicating the medications had been administered. R1, R2, R3, R4 and R5's records lacked evidence the RN conducted an identification and review of all medications the residents were known to be taking to include: - indications for medications. - side effects. - contraindications. - allergic or adverse reactions, and actions to address these issues; and	01700		

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	31334	A. BUILDING: _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	Continued From page 29 - 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 On December 29, 2021, at 1:36 p.m., RN-A acknowledged the provided comprehensive nursing assessments lacked a medication assessment with the required content. RN-A said she thought there was an additional medication assessment. The additional medication assessment was requested, but not provided. The licensee's Medication Management Service Provided by Unlicensed Personnel (ULP) policy dated July 14, 2017, indicated prior to a ULP providing delegated medication administration, "a RN must conduct a face-to-face client assessment to determine what medication management services will be provided and how those services will be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730		

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STONEY RIVER RAMSEY	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
01730	Continued From page 30 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and	01730		

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01730	Continued From page 31 maintain a current individualized medication management record for each resident to include all required content for five of five residents (R1, R2, R3, R4, R5) with records reviewed. 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). The findings include: R1 had diagnoses to include dementia and hypertension. R1's Individualized Service Plan dated December 28, 2021, indicated R1 received medication management services. R2 had diagnoses to include hypertension, and diabetes mellitus. R2's service plan dated December 29, 2021, indicated R2 received services which included assistance with medication management, laundry and housekeeping. On December 29, 2021, at 11:55 a.m. unlicensed personnel (ULP)-D was observed administering medications to R2. R3 had diagnoses to include hypertension, and fibromyalgia. R3's service plan dated December 28, 2021, indicated R3 received services which included assistance with medication management, laundry and housekeeping. R4 had diagnoses to include cancer, diabetes, renal disease, and hypertension. R4's Individualized Service Plan dated December 22, 2021, indicated R4 received medication	01730		

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01730	Continued From page 32 management services. R5 had diagnoses to include diabetes, depression, and hypertension. R5's Individualized Service Plan dated December 1, 2021, indicated R5 received medication management services. R1, R2, R3, R4 and R5's records lacked a medication management plan to include required content noted below: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions, - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. During an interview on December 29, 2021, at 2:03 p.m. registered nurse (RN)-A acknowledged there was no separate medication management plan. RN-A further verified the service plan lacked the content required in a medication management plan. The licensee's Medication Management Plan policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01940	Continued From page 33	01940		
01940 SS=E	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 possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. 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	01940		

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01940	Continued From page 34 plan to include all required content for three of five residents (R2, R4, R5) with records reviewed. 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). The findings include: R2 R2 had diagnoses to include diabetes. On December 29, 2021, at 11:55 a.m. unlicensed personnel (ULP)-D was observed to check R2's blood glucose level. R2's medication administration record (MAR) for December 2021 indicated R2 had Accu-Check (blood glucose monitoring) daily, December 1-28, 2021. R2's service plan dated December 29, 2021, indicated R2 received services which included assistance with medication management, laundry and housekeeping. R2's service plan included a written statement for the treatment services being provided, which included blood glucose monitoring five times per day. R4 R4 had diagnoses to include type II diabetes mellitus. R4's Individualized Service Plan dated December 22, 2021, indicated R4 received services which included assistance with bathing, dressing, grooming, and medication management. R4's service plan included a written statement for the treatment services being provided, which included blood glucose	01940		

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01940	Continued From page 35 monitoring two times per day. R4's MAR for December 2021 included an order for blood glucose checks twice daily. R5 R5 had diagnoses to include type II diabetes mellitus. R5's Individualized Service Plan dated December 1, 2021, indicated R5 received services which included assistance with bathing, dressing, grooming, transfers, and medication management. R5's service plan lacked a written statement for the treatment services being provided, which included blood glucose monitoring four times per day. R5's MAR for December 2021 included an order for blood glucose checks four times daily. R2, R4, R5's records lacked Treatment and Therapy Management Plans to include: - documentation of specific resident instructions relating to the treatment or therapy administration; and - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - any resident-specific requirements relating to documentation of treatment and therapy received' verification all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On December 29, 2021, at 2:03 p.m. registered nurse (RN)-A acknowledged the service plans lacked the content required in the treatment and therapy management plan. The licensee's Treatment and Therapy Management Plan policy was requested, but not provided.	01940		

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01940	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazards and mitigations on and around the property. The hazards indicated on the HVA plan must be assessed and mitigated to protect the residents from harm. This has the potential to directly affect all dementia care residents receiving assisted living services. 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	02040		

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02040	Continued From page 37 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). The findings include: On December 28, 2021, at approximately 3:40 p.m., survey staff received the facility HVA plan documentation, Kaiser Permanente (undated), from the licensed assisted living director (LALD)-B for review. On December 28, 2021, at approximately 4:30 p.m., the HVA documentation review revealed the licensee lacked all the content of the hazard vulnerability assessment to specifically include a comprehensive hazard vulnerability assessment on the property. In addition, no mitigations or safety measures were documented from the assessed hazards itemized on the Kaiser Permanente document to protect residents from harm. On December 28, 2021, at approximately 5:00 p.m. during the interview with LALD-B and the Director of Maintenance (DM)-F, survey staff explained observations were made during the tour with DM-F that the oven and stovetop in the dementia activity areas were accessible to residents and posed a potential hazard to dementia residents. Staff further clarified that the facility was required to develop a complete HVA plan with potential hazards identified, assessed, and mitigated more specific to "on, and around" the licensee's property to protect the dementia residents from harm. The HVA should identified elopement as a potential hazard vulnerability and mitigations to reduce the risk of elopement from exit doors that deactivate during a fire emergency	02040		

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02040	Continued From page 38 and any delayed egress doors that may pose a risk of elopement, as well as the risk and mitigations for the oven and stovetop, to restrict resident access. All potential hazards on and around the property must also be assessed and mitigated in the HVA plan. The LALD-B acknowledged the findings as she explained that her understanding from the licensing meetings and updates was that the Kaiser Permanente document was sufficient to meet this requirement. Survey staff reassured her that the Kaiser Permanente document was a good start, but needed to be expanded to be more comprehensive and specific to the hazard vulnerabilities and mitigations on and around their property to adequately protect residents from all potential harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	03090		

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03090	Continued From page 39 failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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 potential to affect a large portion or all of the residents). The findings include: On December 28, 2021, at approximately 10:00 a.m., the surveyor observed no posted notice to visitors at the facility main entrance regarding electronic monitoring in the facility. On December 28, 2021, at approximately 10:15 a.m. during the entrance conference, licensed assisted living director (LALD)-B confirmed there were no electronic monitoring signs posted at the entrance to the facility. The licensee's Electronic Monitoring policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *12/29/21*
Time: 11:42:44
Report: 1023211300

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.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

HIGH TEMP DISH MACHINE IN USE BUT OPERATOR STATED NO IRREVERSIBLE TEMPERATURE DEVICE. ACQUIRE AND USE SUCH A DEVICE TO ENSURE PROPER SANITIZATION.

Comply By: 12/29/21

2-400 Hygenic Practices

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

OBSERVED OPEN BEVERAGE CONTAINERS IN FOOD PREP AREA. ALWAYS USE CONTAINERS THAT SEAL CLOSED FOR BEVERAGES IN THE FOOD PREP AREA.

Comply By: 12/29/21

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

OBSERVED MOLD ON ICE BIN BAFFLE. MAINTAIN THE ICE MACHINE BIN CLEAN AND

FREE OF MOLD.
Comply By: 12/29/21

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED ACCUMULATION OF FOOD DEBRIS ON TOP SURFACE OF MICROWAVE INTERIOR CAVITY. CLEAN MICROWAVE DAILY.
Comply By: 12/29/21

Surface and Equipment Sanitizers

Hot Water: = at 167 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

S&S: = 800PPM at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

S&S: = 700PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/PEA SOUP
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CUT MELON
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cooling/CHICKEN
Temperature: 115 Degrees Fahrenheit - Location: WALK IN COOLER @ 15 MINUTES
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER #1
Violation Issued: No

Process/Item: Cold Hold/WALDORF SALAD
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER #2
Violation Issued: No

Process/Item: Cold Hold/CUT TOMATO
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold HoldCHEESE
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF RENEE ANDERSON, THE PERSON IN CHARGE, AND ANGELA RICHEY (HRD NURSE EVALUATOR). ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- SERVING HIGH RISK POPULATIONS

DOCUMENTS ON THE FOLLOWING TOPICS WERE INCLUDED WITH INSPECTION REPORT:
- EMPLOYEE ILLNESS TRACKING
- SAMPLE VOMIT CLEAN UP PROCEDURE
- SAMPLE HANDWASHING SIGN
- HIGH RISK POPULATION REQUIREMENTS

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

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 1023211300 of 12/29/21.

Certified Food Protection Manager: DAVID SWINTON

Certification Number: 98642 Expires: 05/08/22

Inspection report reviewed with person in charge and emailed.

Signed: _____

DAVID SWINTON
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us

Report #: 1023211300

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975

No. of RF/PHI Categories Out	2	**Date**	12/29/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:42:44
Legal Authority MN Rules Chapter 4626		**Time Out**	

Establishment	Address	City/State	Zip Code	Telephone
Stoney River Ramsey	14401 Nowthen Boulevard Nw	Ramsey, MN	55303	6126159936

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039421		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A — Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT N/A — Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT N/A N/O — Plant food properly cooked for hot holding		
35		IN OUT N/A N/O — Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/29/21

Inspector (Signature) Gregory T Nelson