

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313341940M
Compliance #: HL313347223C

Date Concluded: June 2, 2026

Name, Address, and County of Licensee

Investigated:

Stoney River Assisted Living
14401 Nowthen Blvd NW
Ramsey, MN 55303
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Not Substantiated

Nature of Investigation:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The resident was neglected when an unlicensed personnel administered the wrong dose of the resident's antiseizure medication causing the resident to become lethargic and sent to the hospital for evaluation.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Although the unlicensed personnel administered an incorrect dose of the resident's antiseizure medication, when a change in condition was observed, the resident was sent to the hospital for further evaluation. The error was an isolated incident and the resident returned to their baseline health status.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical records, hospital records, facility internal investigation, facility incident reports, personnel files,

staff schedules and facility policy and procedures. Also, the investigator observed the facility physical plant, medication administration, treatment administration, provision of care and interaction between staff and the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a history of seizure activity, urinary tract infections (UTI), and diabetes mellitus type one. The resident's service plan included daily assistance with activities of daily living such as dressing, grooming, wheelchair mobility and medication management. The resident's assessment indicated the resident experienced hallucinations and was not independent with decision making. The resident's assessment indicated the resident needed daily assistance from staff with medication management which included blood sugar checks four times per day.

The resident's medical records indicated the resident had an order for Lacosamide, [an antiseizure medication], 100mg to be administered in the morning and 150mg to be administered in the evening.

The resident's medication count log indicated the unlicensed personnel administered the resident's Lacosamide 150mg in the morning. Approximately, six hours later the resident became lethargic, unresponsive and was moving her head moaning. The resident's blood sugar was low, and staff administered orange juice to increase the resident's blood sugar. Staff called 911, reported concerns to the resident's family and provider and the resident was transported to the hospital for further evaluation.

The resident's hospital medical records indicted the resident's blood level of Lacosamide was low, the resident was diagnosed with a seizure, bradycardia, [low pulse rate], UTI and placed on antibiotic treatment. The resident's hospital medical records indicated the resident's neurologist felt the seizure was due to the resident's UTI. The resident returned to the facility approximately four days later.

During an interview the facility nurse stated staff immediately reported the resident's change in condition, and she assessed the resident who appeared to be having a seizure. The facility nurse stated staff later reported that a medication error was found during a medication count and the error was reported to administrative personnel and a management nurse.

During an interview, the resident recalled going to the hospital and having an infection. The resident stated there had been ups and downs during her stay at the facility but described the staff and care as "pretty good". The resident stated she felt safe and could always speak with her provider regarding any concerns.

During an interview, the resident's family member stated a facility nurse informed her of the incident. The family member recalled that the hospital staff could not confirm or deny the resident's symptoms were related to the medication error.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
- (2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: No. The unlicensed personnel declined to interview.

Action taken by facility:

Facility staff immediately observed and reported a change in condition, assessed the resident and sent the resident to the hospital for further evaluation. Following the incident, education on medication administration was provided to facility staff.

Action taken by the Minnesota Department of Health:

No further action taken at this time.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

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 C 04/08/2026
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NAME OF PROVIDER OR SUPPLIER STONEY RIVER RAMSEY	STREET ADDRESS, CITY, STATE, ZIP CODE 14401 NOWTHEN BOULEVARD NW RAMSEY, MN 55303
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p>Initial Comments</p> <p>On April 8, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL313347223C/#HL313341940M.</p> <p>No correction orders are issued.</p>	0 000		

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