Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313349283M
Compliance #: HL313347864C

Date Concluded: May 14, 2025

Name, Address, and County of Licensee Investigated:
Stoney River Ramsey
14401 Nowthen Boulevard Northwest
Ramsey, MN 55303
Anoka County

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

Evaluator's Name: Willette Shafer, RN
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 unknown alleged perpetrator (AP) abused the resident when the resident was sent to the hospital after a reported fall with multiple fractures and extensive bruising inconsistent from a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP completed safety checks on the resident per the resident's care plan. The resident was observed twice during the night in the dining room and was assisted back to his room. The resident's primary care provider said the resident's injuries could have been sustained from a fall. The resident had a history of fractures and most likely had undiagnosed osteoporosis.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed a family member and other residents who lived at the facility. The investigation included review of the resident's record,

hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed staff providing care to residents.

The resident resided in an assisted living facility The resident's diagnoses included dementia, dizziness, weakness, and fainting. The resident's service plan included assistance with medication management, safety checks once per shift, bathing, and housekeeping. The resident's assessment indicated the resident wore hearing aids and glasses but was not wearing these items when he was found on the floor. The resident's memory was declining and recently the facility and family had discussed moving him to memory care.

The internal investigation indicated the resident was found on his bedroom floor lying on his right side. He was alert but confused and was unable to report what happened. He had an abrasion on the right side of his face, a bump on the back of his head and complained of pain in his right arm. His family was notified, and they transported him to the hospital.

The hospital record indicated the resident was diagnosed with multiple fractures including ribs, sternum (middle vertical chest bone that ribs connect to), pelvis, and elbow. The resident sustained a subarachnoid hemorrhage (bleeding in the space between the brain and the tissue covering the brain), and abrasion (rug burn) on right side of face. The resident had recently become more unsteady on his feet but had documented no recent falls. He was recently seen at the hospital for fainting. Due to the extent of the resident's injuries, the hospital suspected possible abuse from the facility. The resident was discharged to a transitional care unit.

During an interview, a member of management said she conducted the internal investigation. She said the resident had several fractures and injuries related to his fall. The incident was reported based on the injuries sustained but she had no concerns of abuse after investigating the incident. She said staff followed the resident's care plan. The resident had a recent decline mentally and physically and family planned to move him to memory care. The resident was kind and well-liked by staff.

During an interview, an unlicensed personnel said she found the resident lying on the floor when she went to administer his morning medication. He was confused and when asked what happened he said something about steps or stairs. Family was contacted and several staff assisted the resident off the floor and the resident was sent to the hospital.

During an interview, a member of management said he responded to the call for assistance after the resident was found on the floor. The resident was observed close to the bathroom with his head facing the bathroom door. It appeared he tried to walk to the bathroom. He said the resident tried to get up several times while staff assessed him, and he needed to be redirected to relax and not get up. He said from the restlessness the resident exhibited while on the ground, the resident most likely fell, got up, and fell again possibly several times.

During an interview, the AP said the resident received safety checks once per shift. She observed the resident twice during her shift. She said he recently had become more confused and wandered down to the dining room for breakfast during the night. The first time she observed him in the dining room she gave him a snack and helped him back to his room. The second time he declined a snack, and she helped him back to his apartment. She never observed the resident on the floor, never harmed the resident, and never witnessed anyone else harm the resident.

During an interview, a family member said the resident sustained his injuries from a fall. She had no concerns about the facility. She said the facility provided excellent care and denied any similar incidents.

During an interview, the resident's primary care provider said the resident sustained his injuries from a reported fall. She said the resident most likely had undiagnosed osteoporosis (weak, brittle bones) and although his injuries were extensive, it was not uncommon for someone his age to sustain these injuries from a fall.

During an interview, resident-2 said the staff were kind and helpful. She had no concerns with the care she received. She said she never observed a staff member verbally or physically abuse her or another resident.

During an interview, residnet-3 said staff were "very good." He said he had never observed a staff member verbally or physically abuse him or another resident. The resident had no concerns about the way staff treat him.

In conclusion, the Minnesota Department of Health determined abuse 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.

Physical Abuse: Minnesota Statutes, section 260E.03, Subd. 18
"Physical abuse" means any physical injury, mental injury under subdivision 13, or threatened injury under subdivision 23, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 125A.0942 or 245.825.

Vulnerable Adult interviewed: No, due to cognitive deficit.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility assessed the resident, called family to report the incident, and sent the resident to the hospital. The facility completed an internal investigation. The facility installed a fall system in resident rooms that detects when a resident falls. The family member and/or residents decide if they want the system activated.

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

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 _____	C 04/25/2025

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 On April 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL313347864C/#HL313349283M. No correction orders are issued.	0 000		