STATE LICENSING COMPLIANCE REPORT

Report #: HL313345061C

Date Concluded: June 21, 2023

Name, Address, and County of Facility Investigated:
Stoney River Ramsey
14401 Nowthen Boulevard NW
Ramsey, MN, 55303

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

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

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 06/07/2023

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

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0 000	Initial Comments ******ATTENTION****** \ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL313345061C On June 7, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 71 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction oorders are issued for #HL313345061C, tag identification 0730, 0990, 1040, 1050.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. 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.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 1 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 2 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary for one of one resident (R1) 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 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: R1 admitted to services on May 5, 2022, and transferred to a hospital on June 28, 2022. After hospitalization, R1 transferred to a transitional care unit (TCU) and did not return back to the facility. R1's record did not include a discharge summary. During an interview on June 13, 2023, at 3:55 p.m., licensed assisted living director (LALD)-A stated R1's record did not include a discharge summary. The licensee's policy titled Discharge Policy,	0 730		

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0 730	Continued From page 3 dated October 1, 2019, indicated the record would contain a discharge summary with reason for discharge, final diagnosis, condition of resident when discharged, provision for continuity of care, and discharge destination. The same policy indicated once complete, the summary was placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 730		
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) The meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are	0 990		

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0 990	Continued From page 4 able to attend the meeting. (c) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (d) In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to schedule and participate in a meeting with the resident and the resident's legal representative and designated representative prior to termination of a contract for one of one resident (R1) who had services terminated. 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).	0 990		

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0 990	Continued From page 5 The findings include: R1's record did not include evidence the licensee conducted the required meeting with the resident and the resident's legal representative and designated representative prior to terminating R1's contract. Review of R1's medical record indicated R1's diagnoses included diabetes. R1 admitted to services on May 5, 2022, and transferred to a hospital on June 28, 2022. After hospitalization, R1 transferred to a transitional care unit (TCU) and did not return back to the facility. R1's Evaluation Resident Form, undated, indicated R1 received services including bathing set up, grooming set up, dressing set up, and medication administration. R1's record included a letter from R1's family indicating the licensee left a voicemail on August 2, 2022, stating R1 needed a higher level of care and R1 was unable to return to the facility. The same letter indicated the licensee did not communicate with R1's family that R1 needed a higher level of care prior to the voicemail left on August 2, 2022, or issued a 30-day notice to R1 and the family. During an interview on June 13, 2023, at 3:55 p.m., licensed assisted living director (LALD)-A stated on August 5, 2022, the TCU held a care conference for R1. The licensee staff did not attend. LALD-A stated the licensee did not participate in a meeting with the resident, the resident's legal representative, and designated representative prior to termination of R1's service contract.	0 990		

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0 990	Continued From page 6 The licensee's policy titled Discharge Policy, dated October 1, 2019, did not include scheduling and participating in a meeting with the resident and the resident's legal representative and designated representative before terminating an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 990		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative.	01040		

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01040	Continued From page 7 (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice for a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination, and failed to provide documentation supporting the need for an expedited termination of their contract for one of one resident (R1) with records reviewed. In addition, the licensee failed to send a copy of the termination notice to the Office of Ombudsman for Long Term Care. 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: Review of R1's medical record indicated R1 admitted to the licensee's services on May 5, 2022, and transferred to a hospital on June 28, 2022. After hospitalization, R1 transferred to a transitional care unit (TCU) and did not return back to the facility.	01040		

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01040	Continued From page 8 R1's record did not include evidence the licensee issued a written notice of termination of contract. R1's record did not include evidence the licensee notified the Office of Ombudsman for Long-Term Care of R1's discharge. R1's record did not include a discharge summary. R1's record included a letter from R1's family that indicated the licensee left a voicemail on August 2, 2022, indicating R1 needed a higher level of care and was unable to return to the facility. The same letter indicated the licensee did not communicate with R1's family that R1 needed a higher level of care prior to the voicemail left on August 2, 2022, or issued a 30-day notice. During an interview on June 13, 2023, at 3:55 p.m., licensed assisted living director (LALD)-A stated the licensee did not have record a written notice of termination was issued for R1 or record a copy of the termination notice sent to the Office of Ombudsman for Long-Term Care. The licensee's policy titled Discharge Policy, dated October 1, 2019, did not include the licensee issuing a written notice of a termination of contract or sending a copy of the notice to the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01040		
01050 SS=D	144G.52 Subd. 8 Content of notice of termination The notice required under subdivision 7 must	01050		

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01050	Continued From page 9 contain, at a minimum: (1) the effective date of the termination of the assisted living contract; (2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale; (3) a detailed explanation of the conditions under which a new or amended contract may be executed; (4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted; (5) a statement that the facility must participate in a coordinated move to another provider or caregiver, as required under section 144G.55; (6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination; (7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination; (8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and (9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a termination notice which	01050		

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01050	Continued From page 10 contained all required information for one of one resident (R1) 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 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: Review of R1's medical record indicated R1 admitted to the licensee's services on May 5, 2022, and transferred to a hospital on June 28, 2022. After hospitalization, R1 transferred to a transitional care unit (TCU) and did not return back to the facility. R1's record did not include evidence the licensee issued a written notice of termination that contained: (1) the effective date of the termination of the assisted living contract; (2) a detailed explanation of the basis for the termination, including the clinical or other supporting rationale; (3) a detailed explanation of the conditions under which a new or amended contract may be executed; (4) a statement that the resident has the right to appeal the termination by requesting a hearing, and information concerning the time frame within which the request must be submitted and the contact information for the agency to which the request must be submitted; (5) a statement that the facility must participate in	01050		

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01050	Continued From page 11 a coordinated move to another provider or caregiver, as required under section 144G.55; (6) the name and contact information of the person employed by the facility with whom the resident may discuss the notice of termination; (7) information on how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to request an advocate to assist regarding the termination; (8) information on how to contact the Senior LinkAge Line under section 256.975, subdivision 7, and an explanation that the Senior LinkAge Line may provide information about other available housing or service options; and (9) if the termination is only for services, a statement that the resident may remain in the facility and may secure any necessary services from another provider of the resident's choosing. R1's record included a letter from R1's family that indicated the licensee left a voicemail on August 2, 2022, indicating R1 needed a higher level of care and was unable to return to the facility. The same letter indicated the licensee did not communicate with R1's family that R1 needed a higher level of care prior to the voicemail left on August 2, 2022, or issued a 30-day notice. During an interview on June 13, 2023, at 3:55 p.m., licensed assisted living director (LALD)-A stated the licensee did not have record a written notice of termination was issued for R1. The licensee's policy titled Discharge Policy, dated October 1, 2019, did not include the licensee issuing a written notice of termination or what the notice must contain. No further information was provided.	01050		

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01050	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01050		