Electronically Delivered

August 12, 2025

Licensee
Stonebay Senior Living
2635 Kelly Parkway
Orono, MN 55356

RE: Project Number(s) SL36734016

Dear Licensee:

On July 1, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 10, 2025. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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May 16, 2025

Licensee
Stonebay Senior Living
2635 Kelly Parkway
Orono, MN 55356

RE: Project Number(s) SL36734016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

(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 ASSISTED LIVING PROVIDER 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: SL36734016-0 On April 7, 2025, through April 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 63 residents; 41 receiving services under the Assisted Living Facility with Dementia Care license. An immediate order was issued on April 8, 2025, for tag identification 1290. During the course of the survey, the licensee took action to mitigate the risk for tag identification 1290. Noncompliance remained and the scope and level remain unchanged. An immediate order was issued on April 9, 2025, for tag identification 2310. On April 9, 2025, the immediate order for tag identificaiton was revised based on additional information provided by the licensee. The scope	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.	

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0 000	Continued From page 1 and level were decreased from an I to a G. During the course of the survey, the licensee took action to mitigate the risk for tag identification 2310. Noncompliance remained and the scope and level remain unchanged.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced	0 470		

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0 470	Continued From page 2 by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed a staffing plan to determine staffing levels to meet the needs of all residents and ensure the staffing plan was reviewed at a minimum of twice a year as required. This had the potential to affect all residents, 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 April 10, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A stated the licensee did not have a staffing plan that was reviewed a minimum of twice per year. LALD-A stated they were unaware that it was required, and staffing was discussed daily in their morning meetings. The licensee's 4.06 Staffing and Scheduling policy dated November 1, 2022, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven days a week. No further information was provided.	0 470		

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0 470	Continued From page 3 TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, 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) 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). Findings include: On a facility tour on April 9,2025, from 11:00 a.m. to 1:00 p.m., with assistant executive director (AD)-B, and director of maintenance (M)-H, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR SPECIAL LOCKING ARRANGEMENTS	0 775		

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0 775	Continued From page 4 There was a controlled egress locking system installed on all exit doors leading out of the dementia care unit to the corridor and to the exterior exit path from the dementia care unit. The controlled egress marked exit door leading to the exterior exit path from the dementia care unit near resident room 117 was not provided with a method to open the door to exit with a key, code, or other means in the event of a fire or similar emergency. It was explained that the controlled egress exit doors are required to be provided with a method to open the door to exit with a key code or other method available and used by staff. The controlled egress door locking system was not provided with a device capable of deactivating the controlled egress door system hardware to the unlocked position from the nurse station or other approved location within the locked unit in order for occupants to exit in the event of an emergency. It was explained the controlled egress locking system is required to be provided with a device capable of deactivating the controlled egress door hardware to the unlocked position from the nurse station or other approved location within the locked unit in order for occupants to exit in the event of an emergency. During an interview at 10:45 a.m., AD-B, stated the procedures required to operate and unlock the delayed egress door locking system were not included in the fire safety and evacuation plan. It was explained that the procedures required to operate and unlock the delayed egress locking	0 775		

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0 775	Continued From page 5 system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. PROPANE CYLINDER STORAGE There was a 20-pound propane cylinder stored within the building in the maintenance office. It was explained to M-H that propane cylinders over 2 pounds shall not be stored within the building in accordance with MSFC and National Fire Protection Association 58. CARBON MONOXIDE ALARMS It was observed there was not a carbon monoxide alarm was installed in resident sleeping unit 215 outside and within ten feet of all sleeping areas. It was explained to AD-B, and M-H, that carbon monoxide alarms are required to be installed inside all sleeping units containing a gas fire appliance in accordance with MSFC in Minnesota Rules Chapter 7511. FIRE ALARM SYSTEM MAINTENANCE During the tour the fire alarm system required annual testing report was requested. During the tour AD-B, stated they would send the documentation of required fire alarms system testing by email. On April 10, 2025, at 10:18 a.m., AD-B, provided an email indicating the documentation for the required annual fire alarm system testing was not	0 775		

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0 775	Continued From page 6 available for 2024. It was explained to AD-B, that annual testing is required for the fire alarm system in order to verify proper operation in the event of a fire. COMMERCIAL KITCHEN HOOD FIRE SUPPRESSION MAINTENANCE During the tour the required annual testing report for the commercial kitchen hood fire suppression system was requested. During the tour AD-B, stated the completion of testing tag from the vendor was installed on the equipment but the test report was not available. It was explained to AD-B, that the required annual commercial kitchen hood fire suppression system test report is required to be available for review in order to verify no deficiencies in the system were noted by service vendor. ELECTRICAL EXTENSION CORD USE There was an electrical extension cord daisy chained (plugged in series and used together) with an electrical power strip and used as permanent wiring in the maintenance office. There was an electrical extension cord fastened with straps and used as permanent wiring to provide power to a refrigerator in the storage room in the Pub near resident sleeping unit 136. It was explained to AD-B, and M-H, that electrical extension cords are required to be used according to manufactures instructions and MSFC in Minnesota Rules Chapter 7511. There was a power cord routed through the	0 775		

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0 775	Continued From page 7 suspended ceiling panel and the metal framework pinching the cord in the commercial kitchen. It was explained to AD-B, and M-H, that electrical cords shall not be routed through building elements and have pressure applied at a pinch point on the cord in accordance with MSFC in Minnesota Rules Chapter 7511. During the facility tour AD-B, and M-H, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 8 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 a facility tour on April 9,2025, from 11:00 a.m. to 1:00 p.m., with assistant executive director (AD)-B, and director of maintenance (M)-H, the surveyor made the following observations of facility disrepair: EMERGENCY STAND BY POWER GENERATOR MAINTENANCE During the tour and interview on April 9, 2025, at 11:15 a.m., the surveyor requested documentation of required maintenance of the emergency stand by power generator. The only documentation provided was the annual service provided by an outside vendor and inspections completed weekly. It was explained that emergency stand by power generators identified as part of the emergency preparedness plan are required to be maintained, tested and serviced on a weekly, monthly and annual schedule in accordance with NFPA 110 (Testing and Service Requirements for Standby Power Systems). During the facility tour AD-B, and M-H, stated the only documentation available for the emergency power generator maintenance was the annual service record and weekly inspection records.	0 800		

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0 800	Continued From page 9 AD-B, and M-H, also stated during the tour that documentation was not available for required monthly run and load testing. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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. (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.	01040		

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01040	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice of termination to one of one resident (R1) and 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) 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 the licensee March 6, 2025, and began receiving assisted living services. R1's diagnoses included Alzheimer's disease with behavioral disturbance, and R1 resided in the secured memory care unit. R1's Assisted Living Facility with Dementia Care Residency Agreement, signed March 6, 2025, indicated the contract may be terminated by either party upon providing at least thirty (30) days advanced written notice to the executive director. R1's progress note dated March 6, 2025, indicated R1 was transferred to the hospital at 10:53 p.m., due to behavioral disturbance. The progress notes also indicated the licensee notified the hospital and R1's daughter on March 12, 2025, at 1:05 p.m., that the licensee would not accept R1's return due to licensee's inability to provide the level of care R1 required.	01040		

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01040	Continued From page 11 R1's discharge care plan dated March 17, 2025, indicated R1 was transferred to the hospital due to being agitated and disruptive. R1's record lacked a written termination notice and lacked documentation a copy of the written termination notice was provided at least 15 days before the effective date to R1, R1's representative, R1's designated representative, and the Office of the Ombudsman of Long-Term Care. During an interview on April 8, 2025, at 7:31 a.m., licensed assisted living director (LALD)-A stated R1 was transferred to the hospital within 6 hours of being admitted. LALD-A stated licensee could not continue caring for R1 as she was requiring as needed (PRN) injectable medication for behavior management. LALD-A stated that a care conference was held with R1's daughter to inform her licensee could not provide the level of care required. LALD-A stated they did not issue a written notice of termination to R1's representative or provide a notice to the Ombudsman. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated February 23, 2023, indicated licensee would not provide as PRN injections. TIME PERIOD OF CORRECTION: Twenty-one (21) days	01040		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a	01060		

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01060	Continued From page 12 resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process	01060		

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01060	Continued From page 13 in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation lasting more than four (4) days for four of five residents (R1, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large number or all of the residents). The findings include: R1 R1 was admitted on March 5, 2025, and began receiving assisted living services. R1's record included a progress note dated March 6, 2025, at 10:53 p.m., indicating resident was transferred to the hospital. R1's record included a discharge summary dated March 12, 2025, indicating resident had been discharged from the facility. R3 R3 was admitted on February 2, 2021, under the licensee's former comprehensive license and began receiving assisted living services on	01060		

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01060	Continued From page 14 August 1, 2021. R3's record included a Service Plan dated December 16, 2024, indicating R3's services included bathing assistance, medication administration, blood glucose management, and mobility assistance. R3's record included progress notes indicting R3 was transferred to the hospital on September 24, 2024, at 10:11 a.m. The progress notes indicated R3 returned from a transitional care facility after 58 days, on November 21, 2024, at 12:20 p.m. R4 R4 was admitted on May 2, 2024, and began receiving assisted living services. R4's record included a signed service plan dated May 7, 2024, indicating R4's services included assistance with dressing and grooming, mobility assistance, medication administration, and safety checks. R4's record included progress notes indicating R4 was transferred to the hospital on February 25, 2025. Progress notes indicated R4 returned from the hospital after seven days on March 4, 2025. R5 R5 was admitted on October 25, 2024, and began receiving assisted living services. R5's record included an unsigned service plan dated November 8, 2024, indicting R5's services included assistance with bathing, medication administration, and safety checks. R5's record included progress notes indicating R5 was transferred to the hospital on December 11,	01060		

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01060	Continued From page 15 2024, and returned after nine days on November 20, 2024. R1, R3, R4, and R5's records lacked evidence of a written notice provided to the resident, the residents' legal representative, designated representative, and OOLTC (for relocations where the resident did not return within four days) that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On April 8, 2024, at 8:04 a.m., licensed assisted living director (LALD)-A stated an emergency relocation notice had not been sent to the resident's representative or to the Office of the Ombudsman for R1. On April 9, 2025, at 12:36 p.m., clinical nurse supervisor (CNS)-C stated emergency relocation notices had not been sent for R3, R4, and R5. CNS-C stated they were not sending emergency relocation notices for any of the residents but would start sending them. The licensee's undated Termination of Residency - Emergency Relocation policy indicated a resident, resident's legal representative, and	01060		

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01060	Continued From page 16 resident's designated representative would be provided a written emergency relocation notice as soon as possible after the relocation. The policy also indicated a copy of the notice would be provided to the Office of the Ombudsman for Long-Term Care within 24 hours if the resident had not returned to the community within four (4) days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a cleared Minnesota Department of Human Services (DHS)	01290	During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope	

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01290	Continued From page 17 background study clearance for two of four employees (unlicensed personnel (ULP)-D, ULP-E). This resulted in an immediate correction order issued on April 8, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: ULP-D ULP- D was hired on October 1, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021. The licensee's NETStudy 2.0 roster dated April 7, 2025, indicated ULP-D was listed with a COVID-19 Study that expired December 31, 2022. A NETStudy 2.0 search conducted April 8, 2025, at 7:54 a.m., indicated ULP-D was affiliated to licensee's health facility identification number (HFID) on June 24, 2022, and separated on August 9, 2022. ULP-D's employee record lacked a cleared DHS background study. ULP-E ULP-E was hired on September 14, 2020, under the licensee's former comprehensive license and	01290	and level remain unchanged.	

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01290	Continued From page 18 began providing assisted living services on August 1, 2021. The Licensee's NETStudy 2.0 Roster dated April 7, 2025, did not include ULP-E. A NETStudy 2.0 search conducted on April 8, 2025, at 7:59 a.m., indicated ULP-E was affiliated to licensee's HFID on June 25, 2021, and separated July 27, 2021. The search also indicted ULP-E was affiliated to licensee's HFID on July 18, 2022, and separated on August 2, 2022. ULP-E's employee record lacked a cleared DHS background study. On April 8, 2025, at approximately 9:30 a.m., assistant director (AD)-B stated they were unaware that ULP-D and ULP-E's background studies had expired. AD-B stated ULP-D was a currently scheduled employee and ULP-E was an on-call employee working during summer breaks from school. On July 29, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. -Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; -If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and	01290		

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01290	Continued From page 19 fully compliant study from their roster at the same time; -All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and -Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's Criminal Background Studies policy revised April 4, 2024, indicated background studies would be performed on all final candidates for employment, whether they are internal or external candidates. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440		

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01440	Continued From page 20 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days of providing services for one of two unlicensed personnel ((ULP)-F). 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). The findings include: ULP-F was hired on November 13, 2023, and began providing assisted living services. ULP-F's record included documentation of competency validation of medication training dated December 19, 2024, and signed by clinical nurse supervisor (CNS)-C.	01440		

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01440	Continued From page 21 On April 8, 2025, at 8:15 a.m., ULP-F was observed administering medication to R4 and R5. ULP-F's record lacked documentation of RN supervision of delegated tasks with 30 days of first performing the delegated tasks. On April 10, 2025, at 2:35 p.m., CNS-C stated they did not complete a 30-day supervision of ULP-F. CNS-C stated ULPs were supervised periodically. The license's 6.17 Supervision of Staff - Delegated Services policy dated February 20, 2024, read "Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the community and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and	01500		

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01500	Continued From page 22 staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01500		

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01500	Continued From page 23 (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 annual training was provided and included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-F). 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: ULP-F was hired on November 13, 2023, and began providing assisted living services. ULP-F's employee record included an undated Educare (online training) transcript that indicated ULP-F had completed annual training in October 2024. ULP-F's record lacked documentation the annual training completed in October 2024 included the following required content: -training on reporting of maltreatment of vulnerable adults under section 626.557; and	01500		

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01500	Continued From page 24 -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. On April 10, 2025, at 2:34 p.m., assistant director (AD)-B stated ULP-F must have had difficulties completing the courses and had not gotten credit for them. The licensee's 5.06 Annual Required Staff Training policy dated November 1, 2022, indicated all staff performing direct care services would complete at least eight (8) hours of annual training every 12 months to include: -training on reporting of maltreatment of vulnerable adults under section 626.557; and -review of the assisted living bill of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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01640	Continued From page 25 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure revised service plans were authenticated by the resident or resident's representative for one of four residents (R4). 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). The findings include: R4 was admitted on May 2, 2024, and began receiving assisted living services. R4's record included a signed service plan dated May 7, 2024, indicating R4's services included assistance with dressing, grooming, catheter care, medication administration, safety checks and assistance with transfers. R4's record included a Service Plan Modification dated April 10, 2025, indicating catheter care and assistance with walking and transfers had been	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 26 removed from R4's service plan. The following services had been added to R4's service plan: -bathing/showering assistance; -bedmaking linen change; -check pendant; -CPAP management/cleaning; -daily wellness check; -daily housekeeping; -medication set up; -medication management plan; -record weight; -skin assessment; and -TED stockings. R4's service plan changes lacked authentication by the facility and the resident or resident's representative documenting agreement on the services to be provided. On April 10, 2025, at 2:10 p.m., clinical nurse supervisor stated R4's catheter had been removed on September 24, 2024, and an updated service plan had not yet been completed for him. The licensee's Development of the Service Plan policy, undated, indicated the service plan and any subsequent modifications must be signed by the resident or the resident's responsible person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

(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
02040	Continued From page 27 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 record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, 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) 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). Findings include: A record review of available documentation and interview were conducted April 9, 2025, at 10:55 a.m., with assistant executive director (AD)-B, and director of maintenance (M)-H, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	04/10/2025

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
02040	Continued From page 28 indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property and building. A hazard vulnerability assessment or safety risk must be performed on and around the property in assisted living with dementia care facilities. The hazards indicated on the assessment must be assessed and mitigated to protect residents from harm. During an interview on April 9, 2025, at 10:55 a.m., AD-B, and M-H, stated an HVA had not been performed and documented on and around the property and building. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36734	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

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02170	Continued From page 29 non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activities evaluation contained all required content for two of two residents (R4, R5) residing in the memory care unit. 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: R4 R4 was admitted May 2, 2024, and began	02170		

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	36734	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

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02170	Continued From page 30 receiving assisted living services. R4's diagnoses included frontal lobe and executive function deficit. R4 resided in the secured dementia care unit. R4's record included a signed service plan dated May 7, 2024, indicating R4's services included assistance with dressing and grooming, medication administration, ambulation and transfer assistance and safety checks. R4's record included an activity assessment completed June 24, 2024. The activity assessment consisted of check boxes listing potential activities of interest and lacked person-centered comments or individualization for the resident. R4's activity assessment lacked the following required content: -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the individuals to participate; and -identification of activities for behavioral interventions. R5 R5 was admitted October 25, 2024, and began receiving assisted living services. R5's diagnoses included unspecified dementia and R5 resided in the secured dementia care unit. R5's record included an unsigned Service Plan dated November 8, 2024, indicating R5's services included assistance with bathing, medication administration, and safety checks. R5's record included an activity assessment completed December 30, 2024. The activity assessment consisted of check boxes listing	02170		

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	36734	A. BUILDING: _____ B. WING _____	04/10/2025

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STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

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02170	Continued From page 31 potential activities of interest and lacked person-centered comments or individualization for the resident. R5's activity assessment lacked the following required content: -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the individuals to participate; and -identification of activities for behavioral interventions. On April 9, 2025, at 1:56 p.m., the surveyor reviewed the statute listing the required content of activity evaluations with licensed assisted living director (LALD)-A. LALD-A stated they were unaware of required content of activity assessments. The licensee's Life Enrichment Programming policy dated February 15, 2023, indicated each resident receiving assisted living services would be evaluated for activities including: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the individuals to participate; and -identification of activities for behavioral interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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	36734	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBAY SENIOR LIVING	2635 KELLY PARKWAY ORONO, MN 55356

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02310	Continued From page 32 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of three residents (R3, R5) who utilized hospital or consumer bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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: R3 R3 was admitted on February 2, 2021, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's Service Plan signed December 17, 2024, indicated R3's services included assistance with showers, medication administration, escorts to meals and activities, blood glucose management, and compression stockings.	02310	During the course of the survey, the licensee took action to mitigate the risk. Noncompliance remained and the scope and level remain unchanged.	

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	36734	A. BUILDING: _____ B. WING _____	04/10/2025

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02310	Continued From page 33 On April 8, 2024, at 8:45 a.m., surveyor observed R3 in a hospital bed with bilateral siderails. R3's record lacked a siderail assessment including purpose of bedrails, measurements of zones of entrapment, and a risk vs. benefit discussion with resident or resident's representative. R5 R5 was admitted on October 25, 2024, and began receiving assisted living services. R5's Service Plan dated November 8, 2024, indicated R5's services included assistance with bathing, medication administration, and safety checks. R5's Service Plan did not indicate R5 required assistance with transfers or mobility. On April 8, 2025, at 8:25 a.m., the surveyor observed Halo rings (consumer bedrails) on both sides of R5's bed. R5's record included a bedrail assessment dated December 23, 2024. The assessment included the type and purpose of the bedrails and indicated a risk vs. benefit discussion had been held with R5's responsible party. R5's record lacked manufacturer's instructions for installation and use of the bedrail. On April 8, 2025, at 2:27 p.m., clinical nurse supervisor (CNS)-C stated she did not think R3 had a siderail assessment as they had recently received the hospital bed. On April 8, 2025, at 3:08 p.m., licensed assisted living director (LALD)-A stated R3's record did not include a siderail assessment.	02310		

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	36734	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 34 On April 8, 2025, at 3:08 p.m., LALD-A stated R5's bedrails were installed by hospice, and they were not sure of the installation date. LALD-A stated they did not have manufacturer instructions for the installation and use of the bedrail. The FDA's, A Guide to Bed Safety, dated October 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:	02310		

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	36734	A. BUILDING: _____ B. WING _____	04/10/2025

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02310	Continued From page 35 - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Siderail Use policy revised November 8, 2019, read "use of siderails and their purpose must be included in the service plan. The use of siderails should be re-evaluated with each assessment, in accordance with State regulations". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *04/08/25*
Time: 17:00:00
Report: 8087251084

Food and Beverage Establishment Inspection Report

Location:
STONEBAY SENIOR LIVING
2635 KELLEY PARKWAY
Orono, MN55356
Hennepin County, 27

Establishment Info:
ID #: 0044104
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Wash Temperature Gauge: = -- at 143 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 187 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 163 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 41 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Air
Temperature: 0 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: -5 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: WHIP CREAM
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT TOMATO
Temperature: 36 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: DICED TOMATO
Temperature: 36 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 37 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

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

Process/Item: Cold Holding:CUT LFY GRN
Temperature: 37 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Hot Holding: GROUND BEEF
Temperature: 138 Degrees Fahrenheit - Location: SERVICE LINE WARMING WELL
Violation Issued: No

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

Type: Full
Date: *04/08/25*
Time: 17:00:00
Report: 8087251084
STONEBAY SENIOR LIVING

Food and Beverage Establishment Inspection Report

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION DONE WITH HEAD CHEF ROHEN "ZEUS" SPENCER.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND TO NURSE EVALUATOR II MICHELLE WINTERS.

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 8087251084 of 04/08/25.

Certified Food Protection Manager: PATRICE M. RAGGS

Certification Number: FM99981 Expires: 04/18/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
ROHEN "ZEUS" SPENCER
HEAD CHEF

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