DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 10, 2023

Licensee
River Pointe Of Moorhead
2401 11th Street South
Moorhead, MN 56560

RE: Project Number(s) SL30646015

Dear Licensee:

On July 6, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 24, 2023, survey were corrected. 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

Electronically Delivered

June 26, 2023

Licensee
River Pointe Of Moorhead
2401 11th Street South
Moorhead, MN 56560

RE: Project Number(s) SL30646015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

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

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

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

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30646	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER POINTE OF MOORHEAD	2401 11TH STREET SOUTH MOORHEAD, MN 56560

(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 ******ATTENTION****** 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: SL30646015 On May 22, 2023, through May 24, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 78 active residents, all of whom were receiving services under the Assisted Living with Dementia Care license.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 23, 2023, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the	0 580		

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0 580	Continued From page 2 quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activities as stated in the licensee's Quality Management Program. This had the potential to affect all 78 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 May 22,2023, at 1:40 p.m., licensed assisted living director (LALD)-A provided the licensee's quality management policy and documentation of quality management activity. The Quality Management Meeting Minutes indicated the following: -July 15, 2022, discussed a procedure for a safe block party for residents, and their friends and	0 580		

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0 580	Continued From page 3 families. -November 15, 2022, discussed procedure for safe environment for Thanksgiving Meal-Expecting 150 people. -February 15, 2023, discussed public bathroom infection control. On May 22, 2023, at 3:45 p.m., LALD-A and clinical nurse supervisor (CNS)-C both stated during the Quality Management meetings they did not review the items as listed in their Quality Management Program. The licensee's undated Quality Management policy indicated data and information that would be evaluated by the Quality Council were: Complaints and feedback from clients, clients' representatives, clients' families, and agency staff; Vulnerable Adult reports to the Minnesota Adult Abuse Reporting Center; Incident reports; Medication errors; Results of audits of client records; Results of audits of personnel files; Current data on dashboard measures; and Results of MDH regular survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the 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	0 730		

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0 730	Continued From page 4 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; (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.	0 730		

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0 730	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of significant changes in the resident's status and actions taken in response to the needs of the resident for one of one residents (R2), failed to document services had been provided as identified in the service plan for one of four residents (R4), and failed to ensure a discharge summary, included all required content for one of one discharged residents (R6). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: DOCUMENTATION OF SIGNIFICANT CHANGE R2 R2's diagnoses included vascular dementia (brain damage due to strokes), hypertension (high blood pressure and Parkinson's disease (disorder of the central nervous system). R2's service plan dated December 14, 2022, indicated R2 received assistance with medication management, compression stockings, dressing, grooming, toileting, mobility, transferring, bathing, and housekeeping.	0 730		

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0 730	Continued From page 6 R2's progress notes dated March 3, 2023, documented by licensed practical nurse (LPN) indicated a wound to the left buttock continues to be open and non-healing with no signs or symptoms of infection, and barrier cream not working. PCP (Primary Care Physician) was notified and ordered Mepilex every three (3) days and prn if soiled. Mepilex (absorbent foam wound dressing) dressing change every three days and PRN (as necessary) if soiled. R2's Assessment dated April 5, 2023, indicated R2 had an open pressure sore to buttock and Mepliex is applied every three days and it was almost healed. On May 24, 2023, at 10:15 a.m., unlicensed personnel (ULP)-J stated the left buttock pressure ulcer on R2 was healed and, "not putting anything on it anymore". On May 24, 2023, at 10:58 a.m., clinical nurse supervisor (CNS)-C stated the licensee was managing R2's wound on left buttock. LPN assessed it [wound] on March 3, 2023, and there was no further documentation of the wound, or the wound was healed. DOCUMENTATION OF SERVICES R4 R4's diagnosis included diabetes and kidney disease. R4's service plan dated May 8, 2023, included safety checks at 1:00 a.m. and 4:00 a.m. R4's May 2023 Service Checkoff List indicated the follow: -1:00 a.m. safety checks were not documented	0 730		

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0 730	Continued From page 7 four of thirteen (13) opportunities; and -4:00 a.m. safety checks were not documented five of thirteen (13) opportunities. On May 24, 2023, at 8:45 a.m., CNS-C stated R4's safety checks were not documented as indicated above. DISCHARGE SUMMARY The licensee's Discharge Resident/Client Roster dated May 22, 2023, indicated R6 was admitted on March 17, 2019, and was discharged on March 31, 2023. R6's diagnoses included chronic airway obstruction. R6's service plan dated March 19, 2022, indicated R6 received the following services: medication management, escorts, laundry, oxygen management, dressing, grooming, and assistance with bathing. R6's discharge summary dated March 14, 2023, did not include the diagnoses, courses of illness, allergies, and a final summary of the resident's status. On May 24, 2023, at 8:45 a.m., CNS-C stated R6's discharge summary did not contain the above identified information. The licensee's undated Content of the Resident Record policy indicated the client record should include 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; documentation of services provided in the service plan; and a discharge	0 730		

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0 730	Continued From page 8 summary, including: a. Diagnosis, Courses of Illnesses, Allergies, Treatments, Therapies, Pertinent Lab Results, Pertinent Radiology results. Pertinent Consultation Results, Final Summary of the resident's status. b. The service termination notice, if applicable. c. The client's status at time of transfer or discharge. d. The disposition of any medications that the agency controlled or stored. e. Other documents relevant to the client's services or status. f. A copy will be provided to the resident, if requested, at time of discharge. If the resident consents, a copy will be provided to the residents designated representative and case manager, if requested, at time of discharge. MN Rule 4659.0120, Subp. 9. Resident discharge summary. At the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes: A. a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; B. a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; C. a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and D. a post discharge plan that is developed with the resident and, with the resident's consent, the	0 730		

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0 730	Continued From page 9 resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a 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	01060		

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01060	Continued From page 10 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 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 to the resident, legal representative, or designated representative. Further, the licensee failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of resident relocation within four days for one of one resident (R2). 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:	01060		

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RIVER POINTE OF MOORHEAD	2401 11TH STREET SOUTH MOORHEAD, MN 56560

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01060	Continued From page 11 R2's service plan dated December 14, 2022, indicated R2 received assistance with medication management, compression stockings, dressing, grooming, toileting, mobility, transferring, bathing, and housekeeping. R2's nurse progress notes included the following: - March 17, 2023, at 10:15 a.m., R2 was admitted to hospital for acute respiratory failure with hypoxia (decrease in oxygen supply to tissues), hypercapnia (decrease in alveolar and blood carbon dioxide) and urinary tract infection. - March 22, 2023, at 11:00 a.m., R2 returned to the facility from the hospital. R2's record lacked documentation R2's designated representative received an emergency relocation notice with all required content and further R2's record lacked documentation the OOLTC was notified of R2's relocation of an overstay of four (4) days. On May 24, 2023, at 12:15 a.m., licensed assisted living director (LALD)-A stated R2 was hospitalized from March 17, 2023, through March 22, 2023. LALD-A stated she did not provide emergency notification notice to the resident's representative or to the OOLTC. She was aware of the emergency relocation regulation; however, since the resident was returning to the facility, she did not think the notification needed to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01440	Continued From page 12	01440		
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 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 direct supervision of unlicensed personnel (ULP) performing delegated tasks was completed by a registered nurse (RN) for one of four employees (ULP-I). 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	01440		

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01440	Continued From page 13 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-I was hired on April 5, 2023, to provide direct care services under the licensee's assisted living with dementia care license. R2's May 2023 Medication Administration Record (MAR) indicated ULP-I administered R2's medications on May 1, 14, 16, and 17, 2023. ULP-I's employee record contained a 30-day Performance Review completed by the licensed practical nurse (LPN) on May 3, 2023. The LPN observed ULP-I performing medication administration and vital signs. ULP-I's employee record lacked evidence direct supervision of ULP performing delegated tasks had been completed by the RN within 30 days of first performing the delegated tasks. The licensee's Supervision of Licensed and Unlicensed Personnel policy (undated) indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform ail the tasks assigned. The RN will directly supervise staff performing delegated nursing tasks and the appropriate licensed health professional will supervise unlicensed staff performing any delegated treatments or assigned therapies.	01440		

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01440	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to assess one of one resident (R1) for change of condition related to falls, as well as failed to implement new interventions to prevent	01620		

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01620	Continued From page 15 future falls. This practice resulted in a level three 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 or in a limited amount of locations). The findings include: R1 was admitted on September 3, 2021. R1's diagnoses included depression, dementia (memory loss), obstructive sleep apnea (intermittent airflow blockage during sleep), Parkinson's disease (disorder of the central nervous system that affects movement), neurocognitive disorder with Lewy bodies dementia (decline in thinking, reasoning, and independent function) and impaired mobility. R1's Service Plan dated December 14, 2022, indicated R1 received medication management, wound care, compression stockings, behavior monitoring, safety checks and assistance with continuous positive airway pressure (CPAP) machine (to aid in breathing while sleeping), bathing, dressing, grooming, toileting, mobility, transfers, housekeeping, and laundry. R1's Service Checkoff list dated May 2023, noted R1 was a high falls risk; safety checks daily at 12:00 a.m., 2:00 a.m., 4:00 a.m., 6:00 a.m., 7:30 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m., 4 p.m., 6:00 p.m., 8:00 p.m., 10:00 p.m.; resident will get	01620		

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up on his own and try walking without a walker, place walker next to him and keep monitoring; keep door propped open so you are able to watch him at all times; refusal of cares, encourage resident and be stern, do not ask, tell him what you are doing with him that day, if still doesn't want to, reapproach and try another staff member.

R1's record indicated from January 2, 2023, through May 3, 2023, R1 had sustained 20 unwitnessed falls, outlined in the incident reports (IR), progress notes (PN) and assessments below:

JANUARY 2023
-IR: January 2, 2023, at 2:35 p.m., unwitnessed fall in resident's living room, unlicensed personnel (ULP), walked into room and saw resident on the floor in front of his recliner. Resident stated was trying to get up and fell. No injuries. The fall was reported to on-call registered nurse (on-call RN-M). The incident investigation report was completed by licensed practical nurse (LPN)-K, and interventions documented was to reeducate on safety, and remind resident to use walker to assist with transfers as needed (PRN).
-IR: January 2, 2023, at 3:45 p.m., unwitnessed fall in common area hallway, ULP heard R1 yelling from the hallway and found him leaning against the corner of the doorway. Resident then leaned forward rubbing the spot on his head (diagram on incident report indicated injury to back of head). Resident stated he wanted to get off the floor, did not tell staff what happened. The fall was reported to on-call RN-M. ULP called family to set up ride to the hospital. The incident investigation report was completed by LPN-K, and interventions documented was to reeducate on safety, and remind resident to use walker to

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01620	Continued From page 17 assist with transfers PRN. -PN: January 2, 2023, at 4:35 p.m., (late entry for January 1, 2023, at 12:14 p.m.) on call RN-M noted received notification via ULP resident fell. No injury. Possibly lost his balance. Directed to notify RN with any changes. -PN: January 2, 2023, at 4:45 p.m., on call RN-M noted received notification via ULP resident had fall. No injury. Directed to notify RN with changes. -PN: January 2, 2023, at 4:49 p.m., on call RN-M noted received notification via ULP resident had fall and had injury to head. Resident sent to emergency room for evaluation. -IR: January 3, 2023, at 10:55 p.m., unwitnessed fall in residents living room, ULP received a page from resident and found him on the floor. Resident stated he fell. No injuries. The fall was reported to clinical nurse supervisor (CNS)-C, the incident investigation report was completed by LPN-K, and interventions documented was to reeducate on safety, and remind resident to use walker to assist with transfers PRN. -PN: January 3, 2023, at 2:40 p.m., LPN-K noted urinalysis ordered. -IR: January 7, 2023, at 10:35 p.m., unwitnessed fall in commons area dining room, ULP was walking by and found him on his back. Resident stated he was trying to find his keys and he fell and could not get up. ULP cleaned up and applied band aid on arm (diagram on incident report indicated injury to left elbow). The fall was reported to CNS-C, the incident investigation report was completed by LPN-K, and interventions documented was to reeducate on safety. -IR: January 8, 2023, at 10:00 a.m., unwitnessed fall in resident's bedroom, ULP received a page and found him against the corner of a wall, without pants or shirt, and blood on the floor. Resident stated he was leaning against the	01620		

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corner of a wall and lost his balance and slid down. Staff cleaned, applied steri-strips and band aids to left arm (diagram on incident report indicated injury to left elbow and hand). The fall was reported to on-call RN-D, the incident investigation report was completed by LPN-K, and interventions documented was to reeducate on safety, and clutter was removed.
-PN: January 8, 2023, at 4:12 p.m., (late entry for January 7, 2023, at 11:00 p.m.) on call RN-D noted received notification from ULP resident had fall and has a new skin tear to left elbow. Directed to notify RN of any changes and to watch skin tear for bleeding and infection.
-PN: January 8, 2023, at 4:18 p.m., (late entry for January 8, 2023, at 10:48 a.m.) on call RN-D noted received notification from ULP resident had a fall and has multiple skin tears to right arm. RN directed staff to clean and dress new skin tears. Directed to notify RN with changes.
-PN: January 9, 2023, at 2:20 p.m., CNS-C noted, urinalysis negative.
-IR: January 10, 2023, at 6:00 p.m., unwitnessed fall in commons area dining room, ULP found lying by a table asking for help. Resident stated he fell off chair. No injuries. The fall was reported to CNS-C, the incident investigation report was completed by LPN-K, and interventions documented was to reeducate on safety, and remind resident to use walker to assist with transfers PRN. Additionally, he had very low blood pressure, staff were instructed to encourage water and snack.
-IR: January 16, 2023, at 5:30 p.m., unwitnessed fall in residents living room, ULP walked into his room and found him face down under his nightstand table. Resident stated he was trying to crawl under his nightstand to grab a cord and got stuck. No injuries. The fall was reported to CNS-C, the incident investigation report was

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completed by LPN-K, and interventions documented was to reeducate on safety, and remind resident to use walker to assist with transfers PRN.
-IR: January 17, 2023, at 8:30 a.m., unwitnessed fall in resident's bedroom, ULP received a page and found him on the floor leaning on the wall. Resident stated he was trying to put on a clean brief, and he lost his balance and fell. ULP cleaned up skin tears and scab (diagram on incident report indicated injury to right and left elbow). The fall was reported to CNS-C, the incident investigation report was completed by LPN-K, and interventions documented was to reeducate on safety, and remind resident to use walker to assist with transfers PRN.
-IR: January 21, 2023, at 2:35 p.m., unwitnessed fall in resident's bedroom, ULP answered call light and found resident on the floor in front of his recliner. Resident stated he fell onto his side table and broke it. No injuries. The fall was reported to licensed assisted living director (LALD)-A. The incident report was completed by ULP, and interventions documented was to have articles of need within easy reach, call cord or other device within easy reach, reeducation on safety.
-PN: January 22, 2023, at 8:13 p.m., (late entry for January 21, 2023, at 3:03 p.m.) on call RN-L noted received notification from ULP resident had lost his balance and fell. No new injury.
-IR: January 27, 2023, at 12:00 p.m., unwitnessed fall in resident's bedroom, ULP found him in front of his recliner. Residents stated he fell. ULP cleaned wounds and dressed injury (diagram on incident report indicated injury to right elbow to hand). The fall was reported to LPN-K, the incident investigation report was completed by LPN-K, and interventions documented was remove trip hazards, reeducation on safety, and remind resident to use

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walker to assist with transfers PRN.
-PN: January 28, 2023, at 8:20 a.m., (late entry for January 27, at 7:10 a.m.) on call RN-M noted received notification from ULP resident had a fall and had multiple skin tears to right arm, with part of nail missing on pinkie finger. It continued to bleed, sent to ER for evaluation. Directed to notify RN with changes.
-PN: January 28, 2023, at 2:20 p.m., on call RN-M was informed by ULP resident was admitted to the hospital. EKG was abnormal, had hyperkalemia. Decreased lisinopril.
-IR: January 30, 2023, at 10:20 p.m., unwitnessed fall in resident's bedroom, ULP found him leaned up against a wall. Resident stated he slid down trying to pick something up. No injuries. The fall was reported to CNS-C, the incident report was completed by LPN-K, and interventions documented was reeducation on safety, and staff to assist with transfers PRN.
-PN: January 30, 2023, at 1:20 p.m., CNS-C noted resident returned from hospital, is weak and hospital physical therapy recommends wheelchair, and is assist of one.

R1's change of condition assessment, dated January 30, 2023, indicated R1 was incontinent of bowel and bladder; skin tears from multiple falls; used a wheelchair and walker; was an assist of one (1) for transfers, bathing, dressing, ambulation and grooming (due to pain in legs and weakness); had shortness of breath with activity; had safety needs for a secured facility; two (2) hour safety checks; and had paranoia and hallucinations.

R1's vulnerable adult assessment, dated January 30, 2023, indicated R1 was a high falls risk and had multiple falls due to decreased safety awareness; had decreased coordination; pain in

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01620	Continued From page 21 his left hip and knee area; was deconditioned and not moving freely without falling; needed assistance with glasses; his environment can be cluttered at times, wife and sister-in-law help tidy up, and removed high fall risk items; he wanders; may refuse cares; and hit at staff. R1's record did not identify a new fall intervention after each fall, nor was an assessment completed after each fall in January 2023. FEBRUARY 2023 R1's 14 day reassessment, dated February 14, 2023, indicated R1 was incontinent of bowel and bladder; required monitoring of skin tears from multiple falls; used a wheelchair and walker; was an assist of one (1) for transfers, bathing, dressing, ambulation and grooming (due to pain in legs and weakness); had shortness of breath with activity; had safety needs for secured facility; two (2) hour safety checks; received home care services; and had paranoia and hallucinations. R1's vulnerable adult assessment dated February 14, 2023, indicated R1 was a high falls risk and had multiple falls due to decreased safety awareness; had decreased coordination; pain in his left hip and knee area; was deconditioned and not moving freely without falling; needed assistance with glasses; his environment can be cluttered at times, wife and sister-in-law help tidy up, and removed high fall risk items; he wanders; may refuse cares; and hit at staff. -IR: February 16, 2023, at 7:30 p.m., unwitnessed fall in resident's bedroom, ULP found on the floor next to his refrigerator. Resident stated he was getting out of his wheelchair and slipped onto the ground. ULP found three (3) different cuts bleeding, cleaned, and applied band aids,	01620		

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01620	Continued From page 22 (diagram on incident report indicated injury to upper left back, lower right back and hand). The fall was reported to CNS-C, the incident investigation report was completed by CNS-C, and interventions documented was chair alarm added, increased lighting including night lights, instructed on safety measure and staff to assist with transfers PRN. -IR: February 23, 2023, at 4:30 p.m., unwitnessed fall in resident's bedroom, ULP heard R1's chair beeping and was on the floor on his back. Resident stated he was trying to pick something up, lost his balance and fell. ULP documented injury as skin tear to right knuckle and opened a new skin tear on top of old one on right elbow (diagram on incident report indicated injury to right elbow and hand). The fall was reported to CNS-C, the incident investigation report was completed by CNS-C, and interventions documented was reeducation on safety, and staff to assist with transfers PRN. -PN: February 26, 2023, at 7:51 p.m., CNS-C noted resident hallucinating, terrible behaviors and chair alarm went off at least 30 times. -IR: February 27, 2023, at 6:30 p.m., unwitnessed fall in resident's living room, ULP heard R1's alarm chair and found him lying on his back. Resident stated he stood up and was walking and fell backward. ULP put band-aid on his skin tear (diagram on incident report indicated an injury to left elbow). The fall was reported to CNS-C, the incident investigation report was completed by CNS-C, and interventions documented reeducation on safety, staff to assist with transfers PRN. R1's record did not identify a new intervention after each fall, nor was an assessment completed after each fall in February 2023.	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER POINTE OF MOORHEAD	2401 11TH STREET SOUTH MOORHEAD, MN 56560

(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
01620	Continued From page 23 MARCH 2023 -IR: March 14, 2023, at 8:30 p.m., unwitnessed fall in commons dining room, ULP saw resident laying on the floor and resident was vomiting. Resident stated he fell. No injuries. After midnight on March 15, 2023, at 4:00 a.m., resident vomiting after slipped from chair, and at 6:45 a.m., resident unresponsive in his room. At 7:15 a.m., resident was sent via ambulance to emergency room. The fall was reported to CNS-C, the incident investigation report was completed by LPN-K. -PN: March 15, 2023, at 7:31 a.m., CNS-C noted received notification from RA three (3) times, resident had fallen and vomited (March 14, 2023, at 9:00 p.m.), had another emesis (March 15, 2023, at 4 a.m., and unresponsive (March 15, 2023, at 6:45 a.m.) CNS-C informed staff to call 911. -PN: March 15, 2023, at 10:30 a.m., CNS-C noted resident was admitted to hospital for severe sepsis. -PN: March 19, at 12:10 p.m., on-call RN-D noted R1 returned from the hospital with new orders of amoxicillin, amlodipine, and quetiapine, and resident back to baseline. R1's change of condition assessment, dated March 20, 2023, indicated R1 was incontinent of bowel and bladder; required assist of two (2) due to decrease in mobility; required monitoring of skin tears from multiple falls; used a wheelchair; was an assist of two (2) for transfers, bathing, dressing, ambulation and grooming (due to deconditioning); had shortness of breath with activity; had safety needs for a secured facility; two (2) hour safety checks; and had paranoia and hallucinations. R1's vulnerable adult assessment dated March	01620		

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01620	Continued From page 24 20, 2023, indicated R1 was a high falls risk and had multiple falls due to decreased safety awareness; had decreased coordination; pain in his left hip and knee area; in wheelchair at all times due to safety, and unable to walk unassisted; needs assistance with glasses; his environment can be cluttered at times, wife and sister-in-law help tidy up, and removed high fall risk items; he wanders; may refuse cares; and hit at staff. -PN: March 20, at 9:15 a.m., CNS-C noted a return assessment was completed and no changes to care plan. -IR: March 23, 2023, at 8:00 a.m., unwitnessed fall in resident's bedroom. No further information on fall or assistance given. The fall was reported to CNS-C, the incident investigation report was completed by LPN-K, and interventions documented was reeducation on safety. -IR: March 23, 2023, at 8:30 a.m., unwitnessed fall in resident's bedroom, ULP found R1 on the floor, ULP called for help. No injuries. The fall was reported to CNS-C, the incident investigation report was completed by LPN-K, and interventions documented was reeducation on safety, and staff to assist with transfers PRN. Additionally, he had recent medication changes from past hospital visit. -PN: March 24, 2023, at 1:25 p.m., LPN-K noted resident had four (4) falls last night due to behaviors/hallucinations. -IR: March 23, 2023, at 7:00 p.m., unwitnessed fall in resident's bedroom, ULP heard R1 yelling for help (incident report did not document specifically where he was found in his room, or how he was laying). Resident stated he was looking for someone and trying to escape his enemies. No injuries. The fall was reported to CNS-C, the incident investigation report was	01620		

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01620	Continued From page 25 completed by LPN-K, and interventions documented reeducation on safety, staff to assist with transfers PRN. -IR: March 23, 2023, at 7:30 p.m., unwitnessed fall in resident's bedroom, ULP documented R1 "hallucinating really bad." ULP called for help, sat resident up in wheelchair and assisted in cleaning his skin tear (diagram on incident report indicated an injury to right elbow). The fall was reported to CNS-C, the incident investigation report was completed by LPN-K, and interventions documented reeducation on safety, staff to assist with transfers PRN. R1's record did not identify a new intervention after each fall, nor was an assessment completed after each fall in March 2023. APRIL 2023 R1's change of condition assessment dated April 3, 2023, indicated R1 was incontinent of bowel and bladder requiring assist of two (2) due to decrease in mobility; required monitoring of skin tears from multiple falls; used a wheelchair; was an assist of two (2) for transfers, bathing, dressing, ambulation and grooming (due to deconditioning); had shortness of breath with activity; had safety needs for a secured facility; two (2) hour safety checks; and had paranoia and hallucinations. R1's vulnerable adult assessment dated April 3, 2023, indicated R1 was a high falls risk and had multiple falls due to decreased safety awareness; had decreased coordination; pain in his left hip and knee area; in wheelchair at all times due to safety, and unable to walk unassisted; needs assistance with glasses; his environment can be cluttered at times, wife and sister-in-law help tidy up, and removed high fall risk items; he wanders;	01620		

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01620	Continued From page 26 may refuse cares; and hit at staff. MAY 2023 -IR: May 3, 2023, at 9:40 a.m., unwitnessed fall in resident's bathroom, ULP found resident laying on the floor next to his closet, and his bed was moved halfway to the door. Resident did not know what happened. No injuries. The fall was reported to CNS-C, the incident investigation report was completed by CNC-C, and no interventions documented. -PN: May 14, 2023, at 10:37 a.m., (late entry for 5/13/2023 at 2:56 p.m.) on-call RN- noted ULP was trying to help resident back into wheelchair and ULP and resident both fell. No injuries. Directed to notify RN with changes. -PN: May 21, 2023, at 5:47 p.m., (late entry for May 20, 2023, at 5:35 p.m.) on-call RN-M noted was found on floor, resident declined vital signs, denied pain or injury, and reported to staff he fell off his chair. Resident refusing medications and asked for food. Resident thought staff were trying to poison him with the drink that was given to him. On May 23, 2023, at 2:30 p.m., CNS-C stated when someone falls, the LPN does the incident report, reports to CNS and interventions are decided as a team. If falls happen on a weekends or evenings, CNS-C is notified via the computer by the the on-call RN. If there is a fall or change in condition, or someone returns from the hospital, whoever is on call RN is expected to assess th resdient. CNS-C stated Falls Prevention Program policy was not followed and she will be doing the falls assessments moving forward. The licensee's undated Nursing Assessment policy indicated the RN will review and update the nursing assessment and service plan at least	01620		

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01620	Continued From page 27 annually and whenever the resident has a change in condition or experiences a fall or other incident. The licensee's undated Fall Prevention Program policy indicated in the initial assessment of a resident or later reassessments, the RN identifies any concerns suggesting that the client may be a risk for falls, the RN will do a focused fall assessment and screening. Based on the falls assessment, the RN will identify any needed interventions, will educate the resident, and will make recommendations about actions the resident should take to reduce the risk of falls. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650		

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01650	Continued From page 28 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R1, R2, R3, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, R3 and R4's Service Plans lacked the following required content: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -a contingency plan to include the action to be taken if scheduled services cannot be provided. R1	01650		

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01650	Continued From page 29 R1's diagnoses included depression, dementia (memory loss), and impaired mobility. R1's Service Plan dated December 14, 2022, indicated R1 received medication management, wound care, compression stockings, bathing, dressing, grooming, toileting, mobility, transfers, housekeeping, and laundry. R2 R2's diagnoses included vascular dementia (brain damage due to strokes), hypertension (high blood pressure and Parkinson's disease (disorder of the central nervous system). R2's Service plan dated December 14, 2022, indicated R2 received medication management, assistance with bathing, dressing, grooming, toileting, wound care, catheter care, housekeeping, and laundry. R3 R3's diagnoses included COPD (chronic obstructive airway disease) and depression. R3's service plan dated April 18, 2023, indicated R3 received assistance with medication management, bathing, dressing, grooming, assistance with CPAP (continuous positive airway pressure) machine, toileting, safety checks, and laundry. R4 R4's diagnoses included diabetes and kidney disease. R4's service plan dated May 8, 2023, indicated R4 received assistance with medication administration, safety checks, and blood glucose monitoring.	01650		

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01650	Continued From page 30 On May 24, 2023, at 8:45 a.m., clinical nurse supervisor (CNS)-C stated R1, R2, R3, R4, and all residents' service plans did not include: the schedule and methods of monitoring assessments of the resident; the schedule and methods of monitoring staff providing services; and a contingency plan to include the action to be taken if scheduled services cannot be provided. The licensee's undated Development of the Service Plan policy, indicated the service plan to include the schedule and methods of monitoring assessments of the resident; the schedule and methods of monitoring staff providing services, and a plan for contingency actions to include the action the agency, the resident and the resident's responsible person will take if scheduled services cannot be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's recommendations.	01880		

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01880	Continued From page 31 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On May 22, 2023, at 1:40 p.m., during the entrance conference, clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to the licensee's residents, including storage of medications. CNS-C stated residents in unsecured unit had refrigerators in their rooms and if any of those residents had medications that required refrigeration, the medications would be stored in the resident's refrigerator. CNS-C stated residents' refrigerator temperatures were not being monitored. CNS-C stated there were medication refrigerators in the nursing offices on the unsecured and secured units. CNS-C stated medication refrigerator temperatures were being monitored twice a day and recorded in the computer for the refrigerators in the nursing offices. The surveyor requested the temperature logs. On May 22, 2023, at 2:55 p.m., during the tour on the secured unit, licensed assisted living director (LALD)-A confirmed the thermometer in the medication refrigerator read 28 degrees Fahrenheit (F) and a bottle of R11's Latanoprost eye drops was stored in the medication refrigerator.	01880		

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01880	Continued From page 32 The medication refrigerator temperature logs for secured unit indicated: -May 21, 2023, at 7:00 a.m., the medication refrigerator temperature was 25 degrees F. -Between March 22, 2023, and May 21, 2023, the medication refrigerator temperatures were documented 109 of 122 opportunities. On May 23, 2023, at 7:10 a.m., unlicensed personnel (ULP)-G confirmed the follow medications were stored in the unsecured unit medication refrigerator (the temperature of the medication refrigerator was 34 degrees F): -a open bottle of Latanoprost eye drops, dated May 10, 2023, belonging to R12; and -a open bottle of Latanoprost eye drops, dated May 10, 2023, belonging to R3. The medication refrigerator temperature logs for unsecured unit indicated: -May 15, 2023, at 3:00 p.m., the medication refrigerator temperature was 50 degrees F. -Between March 22, 2023, and May 21, 2023, the medication refrigerator temperatures were documented 119 of 122 opportunities. On May 22, 2023, at 3: 30 p.m., CNS-C stated the medication refrigerator logs indicated temperatures were not checked twice a day and that temperatures were out of range as indicated above. CNS-C stated she should have been checking the logs, but has not been reviewing the logs. The manufacturer's instructions for Latanoprost eye drops, dated April 29, 2017, indicated to store unopened bottles under refrigeration at 36 degrees F to 46 degrees F. Opened bottles of Latanoprost eye drops were to be kept out of the	01880		

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01880	Continued From page 33 refrigerator for up to six weeks. The licensee's undated Central Storage of Medications policy, indicated medications will not be stored in areas where the temperature may fluctuate to levels that are unsuitable for medication storage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Surveyor: Boutwell, Ann T. Based on observation, interview, and record review, the licensee failed to ensure medications were properly labeled for two of two residents (R7, R8), and failed to date time-sensitive with an expired date for two of two residents (R9, R10). 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 pattern scope (when more than a limited number of residents are affected, more	01890		

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01890	Continued From page 34 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: CONTROLLED MEDICATIONS NOT LABELED PROPERLY On May 23, 2023, at 8:25 a.m., the surveyor observed the locked cabinet inside the secured unit containing narcotic medications with unlicensed personnel (ULP)-E, who stated the three clear boxes contained morphine the nurses draw up for the residents. All three boxes were labeled on the outside with instructions. Inside the boxes were individual syringes not labeled. R7 R7's top of the clear container was labeled with the following instructions: -(resident name), morphine - give two (2) milligram (mg) (0.1 milliliter (ml)) every hour as needed for pain/dyspnea (shortness of breath). Eight (8) unlabeled syringes inside the clear container. R8 R8's top of the clear container was labeled with the following instructions: - (resident name), morphine - give 2 mg (0.1 ml) every hour as needed for pain/dyspnea. Eleven (11) unlabeled syringes inside the clear container. - (resident name), morphine - give 2 mg (0.1) ml buccally three times a day for pain. Twenty-three (23) unlabeled syringes inside the clear container. On May 24, 2023, at 8:45 a.m. clinical nurse supervisor (CNS)-C stated the morphine was not individually labeled and the only label was on top of each clear container.	01890		

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01890	Continued From page 35 TIME SENSITIVE MEDICATIONS On May 23, 2023, at 7:58 a.m., the surveyor observed the medication cupboard in the secured unit with ULP-E. The medication cupboard contained the following: -R9 had a bottle of Lumigan eye drops 0.3 mg per ml eye drops (to lower eye pressure) with an opened date of August 25, 2022, and no expiration date. -R10 had a bottle of Refresh Tears eye drops (used for dry eyes) opened on February 16, 2023, and no expiration date. On May 23, 2023, at 8:00 a.m., unlicensed personnel (ULP)-E was told by CNS-C, the Lumigan and Refresh eye drops would need to be discarded after 28 days from the open date. The manufacturer instructions for the Lumigan eye drops dated January 2019, indicated to discard any remaining solution after four (4) weeks from the date of opening. The manufacturer instructions for the Refresh eye drops dated June 2022, indicated to discard 90 days after opening. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910		

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RIVER POINTE OF MOORHEAD	2401 11TH STREET SOUTH MOORHEAD, MN 56560

(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
01910	Continued From page 36 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R6) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Discharged Resident/Client Roster	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30646	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER POINTE OF MOORHEAD	2401 11TH STREET SOUTH MOORHEAD, MN 56560

(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
01910	Continued From page 37 dated May 22, 2023, indicated R6 was admitted on March 8, 2019, and discharged on February 28, 2023, to a skilled nursing facility. R6's diagnoses included chronic obstructive pulmonary disease (COPD). R6's service plan dated February 8, 2022, indicated R1 received medication administration services. R6's Medication Administration Record (MAR) for February 2023, indicated the resident received the following medications: -alprazolam 0.25 mg (milligrams) three times a day; -aspirin 81 mg daily; -atenolol 50 mg daily; -bumetanide 1 mg daily; -donepezil HCL 10 mg daily; -gabapentin 100 mg, three times daily; -levothyroxine 100 mcg (micrograms), three times a day; -Melatonin 10 mg one tablet at bedtime; -olanzapine 5 mg, on tablet twice a day; -omeprazole 20 mg one tablet twice a day; -potassium chloride 20 mEq (milliequivalent), two tablets daily; -prednisone 5 mg one tablet daily; -Preservision one tablet; twice a day; -Quetiapine 25 mg one tablet daily; -Simvastatin 40 mg one tablet daily; -Trazodone 50 mg, 1/2 tablet at bedtime; and -Venlafaxine 150 mg one tablet daily. R6's record lacked documentation for the disposition of the above noted medications to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30646	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER POINTE OF MOORHEAD	2401 11TH STREET SOUTH MOORHEAD, MN 56560

(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
01910	Continued From page 38 disposition, and names of staff and other individuals involved in the disposition. On May 24, 2023, at 8:45 a.m., clinical nurse supervisor (CNS)-C stated R6's above medications were returned to the pharmacy. CNS-C stated they did not document the disposition of R6's medications. The licensee's Disposition of Medication Policy, (undated) indicated the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *05/23/23*
Time: 14:55:32
Report: 7935231088

Food and Beverage Establishment Inspection Report

Location:
River Pointe Of Moorhead
2401 11th Street South
Moorhead, MN56560
Clay County, 14

Establishment Info:
ID #: 0037701
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182876900
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS OVER SALAD DRESSING AND PRODUCE. MOVED TO BOTTOM OF COOLER DURING INSPECTION.

Corrected on Site

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

STORAGE ROOM HAS BARE CONCRETE FLOOR. PROVIDE APPROVED FLOOR COVERING. POPCORN CEILING IN STORAGE ROOM. CEILING NEEDS TO BE SMOOTH, SO THAT IT IS EASILY CLEANABLE.

Comply By: 05/23/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

PROVIDED BY INSPECTOR.

Corrected on Site

Surface and Equipment Sanitizers

Food and Beverage Establishment Inspection Report

Hot Water: = at 165 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Prep
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Advantco
Violation Issued: No

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 7935231088 of 05/23/23.

Certified Food Protection Manager: Wendy Geller

Certification Number: 81408 Expires: 12/05/24

Signed:_____ Signed: 7935

Establishment Representative 7935

651-201-4500
health.foodlodging@state.mn.us