DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 8, 2022

Administrator
Riverfront On Main
119 North Broadway
Pelican Rapids, MN 56572

RE: Project Number(s) SL28601015

Dear Administrator:

On August 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 11, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

Electronically Delivered

May 25, 2022

Administrator
Riverfront On Main
119 North Broadway
Pelican Rapids, MN 56572

RE: Project Number(s) SL28601015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 11, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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 Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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 Department of Health within 15 business days of the correction order receipt date. 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-508-2791 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28601	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERFRONT ON MAIN	119 NORTH BROADWAY PELICAN RAPIDS, MN 56572

(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 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: SL#28601015 On, May 9, 2022, through May 11, 2022, 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 21 residents, 20 receiving services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on May 10, 2022, issued for SL#28601015, tag identification 2310. On May 10, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a widespread scope and level three (I).	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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). The findings include: During the entrance conference on May 8, 2022, at 11:08 a.m., licensed assisted living director (LALD)-A identified himself as the LALD for the facility. LALD-A obtained an assisted living director license on June 28, 2021. On May 8, 2022, at 1:43 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-A held a current assisted living director license. The BELTSS website did not indicate LALD-A was	0 110		

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0 110	Continued From page 2 listed as the Director of Record for the licensee. On May 8, 2022, at 1:45 p.m., LALD-A confirmed he was not listed as the Director of Record for licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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.	0 480		

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0 480	Continued From page 3 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 9, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780		

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0 780	Continued From page 4 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in all the resident's bedrooms. 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 residents). The findings include: On May 9, 2022, between 1:25 p.m. and 2:30 p.m., survey staff toured the facility with (LALD)-A. During the facility tour, survey staff observed no smoke alarms in the resident's rooms and bedrooms. Seven resident rooms are one bedroom and a living area, and nineteen resident rooms are studio. (LALD)-A verbally confirmed survey staff observations during the facility tour. (LALD)-A stated they would have a contractor install all required smoke alarms in the resident's rooms. No further information was provided.	0 780		

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0 780	Continued From page 5 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP-G) to include all required content with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	01330		

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01330	Continued From page 6 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-G was hired on December 14, 2021, to provide direct care services to residents at the assisted living facility. On May 10, 2022, at 8:00 a.m., the surveyor observed ULP-G to administer R1's scheduled morning medications. ULP-G's employee record lacked evidence of training and competency evaluations for the following topics: - maintenance of a clean and safe environment; - basic nutrition, meal preparation, and food safety; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - understanding appropriate boundaries between staff and residents and the resident's family; - basic knowledge of body functioning and changes in body functioning, injures, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On May 11, 2022, at 11:00 a.m., registered nurse (RN)-C confirmed ULP-G had not completed training and competency evaluations for the above noted topics, as required.	01330		

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01330	Continued From page 7 The licensee's Assisted Living Orientation-ULP Staff policy, dated August 1, 2021, and reviewed on October 1, 2021, verified training and competency evaluations of unlicensed personnel providing assisted living services would be completed by a registered nurse, the training would include: - maintenance of a clean and safe environment; - basic nutrition; - meal preparation; - food safety; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - basic knowledge of body functioning and changes in body functioning; - injures, or other observed changes that must be reported to appropriate personnel; - recognizing physical, emotional, cognitive, and developmental needs of the resident; and - understanding appropriate boundaries between staff and residents and the resident's families. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01330		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained	01420		

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01420	Continued From page 8 in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-D who performed suprapubic catheter (a hollow flexible tube which is inserted via an incision in the lower abdomen and used to drain urine from the bladder) site care for R1. 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-D was hired March 3, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01420		

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01420	Continued From page 9 On May 10, 2022, at 7:25 a.m., the surveyor observed ULP-D, using appropriate technique, to provide R1's suprapubic catheter site care. ULP-D's record lacked documentation to indicate ULP-D had received training and demonstrated competency for suprapubic catheter care. On May 11, 2022, at 11:46 a.m., RN-C confirmed ULP-D had been trained on indwelling catheter care, however lacked evidence that she had been trained and demonstrated competency for providing suprapubic catheter care. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, and reviewed on October 1, 2021, confirmed the RN would verify the ULP was trained and competent and was instructed in the proper methods to perform the task with respect to the specific resident. The RN would document any ULP training and or competencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of	01470		

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01470	Continued From page 10 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	01470		

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RIVERFRONT ON MAIN	119 NORTH BROADWAY PELICAN RAPIDS, MN 56572

(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
01470	Continued From page 11	01470		

isolation, and depression; or
(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 observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees unlicensed personnel (ULP)-G with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-G was hired on December 14, 2021, to provide direct care services to residents at the assisted living facility.

On May 10, 2022, at 8:00 a.m., the surveyor observed ULP-G to administer R1's scheduled morning medications.

ULP-G's employee records lacked the following required orientation content:
- an overview of the 144G statutes;
- the assisted living bill of rights and staff responsibilities related to ensuring the exercise

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01470	Continued From page 12 and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On May 11, 2022, at 10:53 a.m., registered nurse (RN)-C confirmed ULP-G had not completed the above noted orientation as required. The licensee's Assisted Living & Assisted Living with Memory Care Orientation policy dated August 1, 2021 and reviewed on November 3, 2021, verified all assisted living employees would complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. Items to be included, -an overview of Minnesota's assisted living law; -the assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights; -principles of person-centered planning and service delivery and how they apply to direct support services; and -types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		

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01620	Continued From page 13	01620		
01620 SS=D	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 observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment on day 14 for one of one resident (R4) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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01620	Continued From page 14 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: During the entrance conference on May 8, 2022, at approximately 11:10 a.m., RN-B and RN-C stated they completed assessments at admission, every 14 days, every 90 days, and with changes in condition. R4 began receiving assisted living services on February 15, 2022. R4's diagnoses included insomnia, hypertension (high blood pressure), dementia and chronic obstructive pulmonary disease (COPD - chronic obstruction of lung airflow that interferes with normal breathing). R4's service plan dated February 14, 2022, indicated the resident received the following services: medication management, dressing assist, toileting assist, communication/cognition assist, bathing assist, personal hygiene assist, behavior monitoring, and mobility assist escorts. R4's record included an Admission Assessment dated, February 15, 2022, and a 14 day assessment dated, March 2, 2022, one day after the 14 day assessment was due. On May 11, 2022, at 9:19 a.m., RN-B and RN-C confirmed the 14-day assessment had not been completed timely, as required. The licensee's Initial and On-Going Nursing	01620		

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01620	Continued From page 15 Assessment of Residents policy, dated August 1, 2021, and reviewed on October 27, 2021, confirmed a 14-day assessment would be completed up to 14 days after start of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of two residents (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01760		

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01760	Continued From page 16 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: R4's Trelegy Ellipta (used to open airways, keep them open and to reduce inflammation) 200-62.5-25 mcg/inh (microgram/inhalation) was not administered according to manufacturer's instructions. R4's diagnoses included insomnia, hypertension (high blood pressure), dementia and chronic obstructive pulmonary disease (COPD/ chronic obstruction of lung airflow that interferes with normal breathing). R4's service plan dated February 14, 2022, indicated the resident received assistance with all medications. R4's prescriber orders dated March 1, 2022, stated "ok to use trilogy [sic] as instructed." R4's medication administration record (MAR), dated May 1, 2022, through May 10, 2022, written instructions were, "1 puff inhale orally one time a day for COPD rinse mouth with water after use". On May 10, 2022, at 7:46 a.m., the surveyor observed unlicensed personnel (ULP)-G conduct a medication pass for R4 which included administration of a Trelegy inhaler. ULP-G handed the inhaler to R4 and instructed her to breath in. R4 handed the inhaler back to ULP-G. ULP-G did not instruct the resident to rinse her mouth out after the administration of the inhaler.	01760		

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01760	Continued From page 17 ULP-G proceeded to the medication cart to complete medication administration records. On May 10, 2022, at 8:00 a.m., following the above medication pass observation, ULP-G confirmed she had not instructed R4 to rinse her mouth out following administration of the Trelegy inhaler. ULP- G confirmed the direction on the box of the Trelegy inhaler provided instructions to rinse mouth out after use. The manufacturer's instructions for use of the Trelegy inhaler dated October 2020, indicated the resident should rinse their mouth with water after use, and not to swallow the water. On May 10, 2022, registered nurse (RN)-C confirmed her expectation would be staff either give inhaler first and then medication and water or to have staff give water after inhaler. The licensee's Administration and Documentation of PRN (as needed) Medications dated August 1, 2021, and reviewed on December 2, 2021, confirmed medication would be administered consistent with parameters specified in the prescriber's prescription and with the procedures identified by the RN for administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

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01880	Continued From page 18 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 the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. 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: On May 9, 2022, at 11:44 a.m., the surveyor toured the facility with registered nurse (RN)-C, including a review of the locked medication refrigerator. RN-C confirmed the current refrigerator temperature was 39 degrees Fahrenheit (F). RN-C stated the temperatures for this refrigerator should be monitored and recorded daily in their electronic record. The refrigerator contained one bottle of Refresh liquid gel 0.5 milligrams (mg) (lubricating eye drop solution) [unknown resident]. The surveyor asked for the medication refrigerator logs for April and May 2022. On May 9, 2022, at 2:18 p.m., RN-B and RN-C confirmed the licensee did not have temperature logs for the medication refrigerator and would be	01880		

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01880	Continued From page 19 implementing a daily medication refrigerator temperature log immediately. The manufacturer's instructions for Refresh liquid gel dated March 2018, indicated the eye drop solution should be stored at 59-86 degrees F. The licensee's Storage of Medications policy dated December 1, 2021, noted the RN would recommend where medications should be stored and would provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool place, dry area, and according to manufacturer's recommendations. This may include a combination of the resident's room and the nursing office. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription	01890		

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01890	Continued From page 20 label with legible information including the expiration date for time sensitive medications for three of three residents (R1, R4, unknown resident). 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: On May 9, 2022, at 11:44 a.m., the surveyor toured the facility with registered nurse (RN)-C, including a review of the locked medication refrigerator and medication cart. RN-C observed and confirmed the following: R1 R1's warfarin (blood thinner) blister pack (a transparent, molded piece of plastic, often sealed to a sheet of cardboard, used to package tablets) did not have an original prescription label with information regarding the medication name and medication dosage. R4 R4's open tubes of Nystatin cream (used to treat fungal infections) and Diclofenac Sodium topical gel 0.1% (a topical pain medication) both lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy of which the medication had been issued.	01890		

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01890	Continued From page 21	01890		

R4's Trelegy Ellipta 100 micrograms (mcg)/62.5 mcg/25 mcg inhaler (steroid bronchodilator) did not have a label which indicated the date the inhaler had been removed from the foil tray and when the inhaler would expire.

Unknown Resident
A bottle of Refresh liquid gel 0.5 milligrams (mg) (lubricating eye drop solution) did not have an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy of which the medication had been issued. In addition, the solution did not have a label which indicated the date the eye drop solution had been opened and when the solution would expire.

On May 9, 2022, at 11:58 a.m., directly following the above observation RN-C confirmed all medications should have an original prescription label and time sensitive medications should be dated with a when opened and expiration date.

The manufacturer's instructions for Trelegy Ellipta dated January 2019, directed to discard the inhaler six weeks after it had been removed from the foil tray.

The manufacturer's instructions for Refresh liquid gel dated March 2018, directed to discard the eye drop solution 90 days after opening.

The licensee's Storage of Medications policy dated December 1, 2021, noted a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's

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01890	Continued From page 22 name, prescriber's name, date of issue and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that 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: 2040 Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. 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	02040		

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02040	Continued From page 23 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 residents). The findings include: A review of the Hazard Vulnerability Assessment showed global issues such as fire, gas leaks, and epidemics had been identified. Local hazards that are site, building, and population-specific had not been developed. During an interview on May 9, 2022, at 1:25 p.m., the licensed assisted living director (LALD)-A stated he had not completed the hazard vulnerability assessment on and around the facility property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are	02110		

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02110	Continued From page 24 person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in for two of two residents (R1, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	02110		

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02110	Continued From page 25 or has the potential to affect a large portion or all of the residents). The findings include: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 28 residents. R1 R1's record lacked documentation of receipt of required policies and procedures to be provided to the residents and the residents' legal and designated representatives at the time of move-in. R4 R4's record lacked documentation of receipt of required policies and procedures to be provided to the residents and the residents' legal and designated representatives at the time of move-in. On May 11, 2022, at 11:21 a.m., the licensed assisted living director (LALD) confirmed none of the residents and/or legal representatives received the inclusive list of dementia care policies and procedures as required at the time of move-in to the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28601	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERFRONT ON MAIN	119 NORTH BROADWAY PELICAN RAPIDS, MN 56572

(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
02170	Continued From page 26	02170		
02170 SS=D	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 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.	02170		

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02170	Continued From page 27 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a comprehensive evaluation for an activity plan for one of two residents (R4) who received services under an assisted living with dementia care license. 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 was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R4 R4's diagnoses included insomnia, hypertension (high blood pressure), dementia and chronic obstructive pulmonary disease (COPD - chronic obstruction of lung airflow that interferes with normal breathing). R4's undated Activity Assessment identified R4's past and current activity preferences and preferred activity setting, however the assessment did not include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral	02170		

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02170	Continued From page 28 interventions. In addition, R4's record lacked the development of an individualized activity plan. On May 11, 2022, at 11:24 a.m., registered nurse (RN)-C confirmed the licensee had not completed a comprehensive activity evaluation or developed an activity plan for R4 or for other residents as required. The licensee's Description of Life Enrichment Programs and how Activities are Implemented in ALCD policy dated August 1, 2021, and reviewed on March 1, 2022, verified each resident receiving assisted living services would be evaluated for activities. The evaluation would include; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitation; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. And a selection of daily structured and non-structured activities would be provided, as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under	02240		

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02240	Continued From page 29 section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained.	02240		

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02240	Continued From page 30 Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R1's diagnoses included hypertension (HTN-high blood pressure), leukemia, anxiety and chronic suprapubic catheter (a hollow flexible tube which is inserted via an incision in the lower abdomen and used to drain urine from the bladder). R1's record included an acknowledgement dated December 3, 2020, that the resident's representative had received the Minnesota Home Care Bill of Rights for Assisted living Clients of Licensed Only Home Care Providers dated November 14, 2019. On May 11, 2022, at 9:27 a.m., licensed assisted	02240		

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02240	Continued From page 31 living director (LALD)-A stated he thought they had issued the new Minnesota Bill of Rights for Assisted Living Residents to all residents, however, was unsure of where this would have been documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (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 three of three residents (R1, R4, R5) with bedrails. In addition, the licensee did not adhere the United States Consumer Product Safety Commission (USCPSC) recall of portable bedrails. This resulted in an immediate correction order on May 10, 2022, at approximately 11:14 a.m. 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 a widespread scope (when problems	02310		

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02310	Continued From page 32	02310		

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:

R1
On May 10, 2022, at 7:25 a.m., the surveyor observed R1 laying in his bed on his right side. R1's bed had a single upper bedrail on the right side of the bed which was held in place between the mattress and the box spring; but did not secure to the bed frame or any other surface. The surveyor observed unlicensed personnel (ULP)-D to provide suprapubic catheter (a hollow flexible tube which is inserted via an incision in the lower abdomen and used to drain urine from the bladder) care, perineal care, apply compression socks and assisted the R1 with dressing. At 7:49 a.m., the surveyor observed ULP-D to assist R1 to a seated position on the side of the bed. R1 used the bedrail to assist himself into an upright position and dangled his legs over the right side of the bed. The bedrail did move outward as R1 placed pressure on the rail.

R1's diagnoses included, leukemia, chronic suprapubic catheter, anxiety, weakness, atrial fibrillation (irregular often fast heart rate), and hypertension (HTN-high blood pressure).

R1's Task List Report printed May 10, 2022, indicated the resident received the following services, catheter care, dressing, grooming, housekeeping, and thromboembolism stockings (TEDS).

R1's Bed Rail Consent dated October 30, 2017, indicated the reason for the bedrail was for safety and repositioning. The consent indicated the risk

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02310	Continued From page 33	02310		

and benefits of bedrails had been provided to R1. The assessment did not include measurements of the entrapment zones.

On May 10, 2022, at 9:19 a.m., registered nurse RN-C confirmed R1's most current bedrail assessment was dated October 30, 2017. RN-C stated the process to assess a resident's bedrail was at the time of move-in or when they are made aware the resident has a bedrail the RN conducts an assessment and provides education and a risk and benefit for the bedrail with the resident. RN-C stated they have used a variety of bedrail assessment forms over time and the most current one was implemented about a month ago. RN-C verified R1's current bedrail assessment did not include measurements of the entrapment zones. RN-C stated they did not monitor bedrails for recalls.

On May 10, 2022, at 9:29 a.m., the surveyor observed RN-B measure R1's bedrail. The bedrail measured 18 ¾ inches wide by 4 ¾'s inches tall, which exceeds the FDA guidelines for bedrails. RN-B verified R1's bedrail was held in place by bars placed between the mattress and the box spring and not securely attached to the bed. RN-B stated R1 used the bedrail for mobility.

R4
On May 10, 2022, at 6:56 a.m., the surveyor observed R4 laying in her bed on her back. R4's bed was against the wall, and it had an upper bedrail on the side of the bed R4 would exit from. The surveyor observed unlicensed personnel (ULP)-E and ULP-F assisting R4 with changing her brief and repositioning her.

R4's diagnoses included dementia.

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02310	Continued From page 34 R4's Task List Report printed May 10, 2022, indicated the resident received the following services, toileting assist, dressing assist, and behavior monitoring. R4's record did not include a bedrail assessment. On May 10, 2022, at 9:20 a.m., RN-C confirmed a bedrail assessment was not completed for R4 and stated "her family brought it [bedrail] in within the last two weeks." On May 10, 2022, at 9:45 a.m., surveyor observed RN-B measured R4's bedrail. The bedrail opening measured 3 inches wide by 23 long, which is in compliance with FDA guidelines for bedrails. The bedrail was attached to the bed with a strap with went under the frame of the bed and connected to itself. Pressure was placed on the bedrail and it was firm against the bed. R5 On May 10, 2022, at 7:04 a.m., the surveyor observed R5 laying in her bed on her back. R5's bed was against the wall, and it had bilateral upper bedrails in the raised position. The surveyor observed unlicensed personnel (ULP)-E and ULP-F assisting R5 with her perineal care, dressing, and transferring her into a tilt-n-space wheelchair. R5's diagnoses included Alzheimer's disease and hypertension (high blood pressure). R5's Task List Report printed May 10, 2022, indicated the resident received the following services, grooming assist, toileting assist, dressing assist, and behavior monitoring. R5's record did not include a bedrail assessment.	02310		

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02310	Continued From page 35 On May 10, 2022, at 9:20 a.m., surveyor observed RN-B measured R4's bedrail. The bedrail opening measured 2 inches wide by 9 which is in compliance with FDA guidelines for bedrails. Pressure was placed on the bedrail, and RN-C confirmed it was "wobbly" and not securely fastened to the bed. On May 10, 2022, at 9:45 a.m., registered nurse (RN)-C confirmed R5 used her bedrails to assist staff with repositioning. RN-C stated she does not have a bedrail assessment for R5, "I gave it to her husband to sign." RN-C added he gives everything back "unsigned." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The FDA "A Guide to Bed Safety" revised April 2010, included the 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 United States Consumer Product Safety Commission (USCPSC) dated April 29, 2021, identified a recall involving adult portable bedrails that do not have safety retention straps to secure	02310		

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02310	Continued From page 36 the bedrail to the bed frame to keep the bedrail from shifting out of place and creating a dangerous gap. This poses a serious risk for strangulation, entrapment, and death. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy was removed as confirmed by documentation, observation and review by the evaluation supervisor on May 10, 2022, at 3:30 p.m.; however, noncompliance remains.	02310		

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

Type: Full
Date: *05/09/22*
Time: 12:00:53
Report: 7935221117

Food and Beverage Establishment Inspection Report

Location:
Riverfront On Main
119 North Broadway
Pelican Rapids, MN56572
Otter Tail County, 56

Establishment Info:
ID #: 0038577
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188632991
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.

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

DISCARD HARDBOILED EGGS DATED 5/1.

Corrected on Site

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

HAND WASHING SIGN WAS PRINTED AND HUNG DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 167 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *05/09/22*
Time: 12:00:53
Report: 7935221117
Riverfront On Main

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Hobart
Violation Issued: No

Process/Item: Hot Holding
Temperature: 142 Degrees Fahrenheit - Location: Soup
Violation Issued: No

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

Unopened box of unpasteurized eggs in the walk in cooler. Wrong eggs were delivered. Kitchen manager will return these to food service provider.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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 7935221117 of 05/09/22.

Certified Food Protection Manager: Christopher Friday

Certification Number: 20715 Expires: 02/13/24

Signed: _____ Signed: 7935

Establishment Representative 7935

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