Electronically Delivered

April 25, 2025

Licensee
Riverfront on Main
119 North Broadway
Pelican Rapids, MN 56572

RE: Project Number(s) SL28601016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Riverfront on Main. Please contact Jessie Chenze at 218-332-5175 on or before Wednesday, April 30, 2025, to schedule the conference call.

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

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 _____	03/26/2025

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 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: SL28601016-0 On March 24, 2025, through March 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 23 residents; 23 receiving services under the Assisted Living Facility 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	0 100		

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0 100	Continued From page 1 facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee rented out use of the facility space to operate a daycare and private business. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 24, 2025, at 9:11 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On March 24, 2025, at 8:57 a.m., the surveyor arrived at the assisted living facility. The surveyor observed signage of two additional business located on the lower level of the facility with private entrances. On March 24, 2025, at 10:49 a.m., clinical nurse supervisor (CNS)-C stated the lower level of the building included the assisted living's laundry room, a rented space for a daycare, and a rented	0 100		

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0 100	Continued From page 3 space for a private business. On March 24, 2025, at 10:53 a.m., LALD-A stated the assisted living owns the entire building, however, rented out spaces in the lower level. LALD-A further stated no assisted living services were provided in the lower level besides resident's laundry. On March 24, 2025, at 11:14 a.m., the surveyor toured the lower level with LALD-A. To gain access to the lower level, LALD-A used a key fob for the elevator. The lower level included a laundry room, storage room, mechanical room, three offices rented out to a private business, and a day care center. LALD-A stated the private business and daycare only had access to the lower level of the building with each having their own private entrance. On March 25, 2025, at 1:24 p.m., the Minnesota Department of Health (MDH) engineer surveyor stated the private business, daycare, and assisted living shared the same address, utilities, and were all located in one building. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed	0 480		

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0 480	Continued From page 4 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb	0 480		

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0 480	Continued From page 5 breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	0 485		

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0 485	Continued From page 6 All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 24, 2025, at 9:15 a.m., licensed assisted living	0 485		

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0 485	Continued From page 7 director (LALD)-A stated the licensee provided residents three meals per day and the licensee did not require a resident to include and pay for meals in their contract that the resident did not want. The licensee's undated Features and Amenities indicated amenities included in the monthly house service fee included three nutritious meals plus afternoon snacks. On page 13 of the licensee's 2024 Resident Handbook indicated three meals a day were provided in the rental base monthly package but may be opted out of at any time. Resident assisted living contracts and monthly house service fee lacked an option for residents to opt out of payment for one or two meals residents would not want. On March 25, 2025, at 3:04 p.m., LALD-A stated the licensee written meal plan option was opting in to receive all meals or opting out of all meals, however, the licensee worked with residents to accommodate the number of meals each resident wanted. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated December 13, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 650	Continued From page 8	0 650		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-D, registered nurse (RN)-B). 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	0 650		

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0 650	Continued From page 9 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: During the entrance conference on March 24, 2025, at 9:23 a.m., clinical nurse supervisor (CNS)-C stated the licensee was aware of the required contents of the employee record. ULP-D ULP-D was hired on June 3, 2022, to provide direct care services to residents at the assisted living. On March 25, 2025, at 7:04 a.m., the surveyor observed ULP-D provide scheduled morning medication to R4. ULP-D's employee record lacked an annual performance review for 2023 and 2024. On March 25, 2025, at 12:17 p.m., CNS-C stated ULP-D's employee record lacked annual reviews and the licensee was supposed to complete employee reviews every year. RN-B RN-B was hired on June 25, 2015, and had begun providing direct care services with supervision to residents and staff at the assisted living effective August 1, 2021. RN-B's employee record contained an annual performance review dated October 3, 2023, however, lacked an annual performance review	0 650		

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0 650	Continued From page 10 for 2024. On March 25, 2025, at 12:17 p.m., CNS-C stated RN-B's annual review for 2024 was not completed and an annual review should have been done for RN-B. The licensee's Personnel Record policy dated February 19, 2024, indicated the personnel record for each person will include annual performance evaluations which identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=E	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680		

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0 680	Continued From page 11 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the minimum inspection frequency for the emergency power generator as part of the emergency plan to ensure the proper performance of the generator. 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 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 March 25, 2025, at 11:40 a.m., the surveyor toured the facility with director of maintenance (DM)-E and licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed an emergency power generator. During the facility tour interview, LALD-A stated the emergency power generator was part of the emergency plan. On March 25, 2025, DM-E provided generator inspection and testing records. Emergency generator records indicated the generator was inspected and tested monthly. During an interview on March 25, 2025, at	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 12 approximately 1:30 p.m., DM-E stated they were not aware weekly generator inspections were required and verified these inspections had not been completed at the required frequency. The licensee failed to meet the minimum frequency requirements of inspections and testing for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. TIME PERIOD FOR CORRECTION: Seven (7) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect more than a limited number of 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 pattern scope (when more than a limited number	0 775		

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 _____	03/26/2025

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RIVERFRONT ON MAIN	119 NORTH BROADWAY PELICAN RAPIDS, MN 56572

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0 775	Continued From page 13 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 March 25, 2025, at 11:40 a.m., the surveyor toured the facility with director of maintenance (DM)-E and licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: FIRE ALARM SYSTEM The inspection tag for the fire alarm panel was dated February 2024 indicating an annual inspection had not been completed on the fire alarm system. During the facility tour interview, DM-E and LALD-A verified the fire alarm system had not been inspected in the last year and stated the service provider was scheduled to complete this inspection next week. CONTROLLED EGRESS DOOR SYSTEM PROCEDURES Electromagnetic locks with keypads were installed on emergency exit doors. On March 25, 2025, LALD-A and DM-E provided emergency plan procedures. Record review indicated the emergency plan did not include procedures to operate and unlock the electromagnetic controlled locking door system. During an interview on March 25, 2025, at 3:00 p.m., LALD-A verified this information was not included in the plan. EXTENSION CORD USE Extension cords were used to supply power in the employee lounge and resident room 113, creating a fire hazard. During the tour interview, DM-E and LALD-A verified the above listed observations.	0 775		

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0 775	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 15 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain all parts of the fire safety and evacuation plan readily available and provide required training. This had the potential to directly affect more than a limited number of 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 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 March 25, 2025, licensed assisted living director (LALD)-A and maintenance director (DM)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review indicated the FSEP in the disaster plan binder did not include evacuation procedures for the individualized unique needs of residents. During an interview on March 25, 2025, at 3:00 p.m., LALD-A stated residents requiring staff assistance in an emergency had been identified and these procedures were maintained electronically on the computer. These individualized evacuation procedures were not included with the printed copy of the FSEP in the disaster plan binder. All parts of the FSEP must be maintained as readily available for accessibility. TRAINING	0 810		

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0 810	Continued From page 16 Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by a review of training documentation lacking the required frequency. A site specific FSEP annual employee training was completed on September 24, 2024. No additional FSEP training records were provided. During an interview on March 25, 2025, at 3:00 p.m., LALD-A stated employees had completed fire safety and evacuation training in November 2024 from an online course provider and verified this was not a site specific FSEP training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01290		

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01290	Continued From page 17 licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) for one of ten employees (cook (C)-J). 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: During the entrance conference on March 24, 2025, at 9:23 a.m., clinical nurse supervisor (CNS)-C stated the licensee was aware of the required contents of the employee record. C-J was hired on October 17, 1988, and had begun cooking for assisted living residents at the facility effective August 1, 2021. On March 25, 2025, at 11:21 a.m., registered nurse (RN)-B stated C-J was a current cook for the licensee. The surveyor reviewed the NETStudy 2.0 Roster provided by licensed assisted living director (LALD)-A and questioned why C-J was not listed as a current employee on the NETStudy 2.0 Roster. LALD-A stated LALD-A needed to review information on the NETStudy 2.0 website and get it (C-J's background study) figured out. On March 25, 2025, at 3:00 p.m., LALD-A provided the surveyor an updated NETStudy 2.0 Roster, which listed C-J as a current employee,	01290		

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01290	Continued From page 18 determination was "Closed- Eligible in NS1 (previous background study website), and C-J was affiliated to the licensee effective March 25, 2025. LALD-A stated C-J had a cleared background study under the licensee's sister facility and LALD-A affiliated C-J to the correct HFID for the licensee after the surveyor questioned why C-J was not listed on the original NETStudy 2.0 Roster provided. LALD-A further stated human resources had completed an audit of all employee's background checks to ensure the correct affiliation HFID number, however, C-J's background study must have been affiliated to the wrong HFID. The licensee's Personnel Records policy dated February 19, 2024, indicated all personnel records would contain documentation of a completed background study. The licensee's Background Checks policy dated February 12, 2024, indicated all employees of the facility with direct resident contact will undergo a background study through DHS. The policy did not address background study affiliation. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
02310 SS=F	144G.91 Subd. 4 (a) 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.	02310		

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02310	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were appropriate based on the needs of residents who reside in the facility with regards to safely storing chemicals. This had the potential to affect all 23 residents, staff, and visitors. In addition, the licensee failed to ensure oxygen was stored safely for one of one resident (R3). 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: During the entrance conference on March 24, 2025, at 9:11 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. CHEMICAL STORAGE The licensee held an assisted living with dementia care license effective July 1, 2024, and expired June 30, 2025. On March 25, 2025, at 8:30 a.m., unlicensed personnel (ULP)-H and the surveyor observed three containers of Great Value Disinfecting Wipes in R7's bathroom. ULP-D stated the disinfectant wipes were not secured and R7's husband had brought the disinfectant wipes into	02310		

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02310	Continued From page 20 R7's bathroom. ULP-D further stated ULP-D had told R7's husband disinfectant wipes needed to be secured in the locked environmental health closet. On March 25, 2025, at 10:34 a.m., the surveyor and ULP-H observed a wall of cabinets, without locks, located in the shared resident living room area. ULP-H stated any resident, staff, or visitors had access to supplies in the cabinet. The lower unlocked cabinet contained the following chemicals: -three opened bottles of Clean on the Go Air Odor Eliminator; and -two opened bottles of Comet Disinfectant with Bleach Spray. Immediately following the observation, ULP-H stated all chemicals were supposed to be locked in the environmental health closet. On March 25, 2025, at 10:39 a.m., ULP-D stated all chemicals were stored in the locked environmental health closet. On March 25, 2025, at 10:49 a.m., ULP-G stated ULPs were trained to store all cleaning chemicals in the locked environmental health closet or in the locked employee break room. On March 25, 2025, at 3:08 p.m., clinical nurse supervisor (CNS)-C stated all chemicals that had the potential to be harmful to residents were supposed to be stored in the locked environmental health closet. CNS-C further stated ULPs were trained to remove any chemicals in an unsecured area, place the chemical in the locked environmental health closet, and notify the ULPs supervisor of the finding.	02310		

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02310	Continued From page 21 The Material Safety Data Sheet for Great Value Disinfecting Wipes dated June 16, 2010, indicated to avoid eye contact, inhalation, skin contact or ingestion. In addition, keep out of the reach of children. The Safety Data Sheet for Clean on the Go Airlift Clear Air Odor Eliminator dated September 11, 2015, indicated it causes skin irritation, serious eye damage, may cause an allergic skin reaction, harmful if swallowed, and to keep out of reach of children. The Safety Data Sheet for Bleach Disinfectant Cleaner dated January 13, 2021, indicated may cause an allergic skin reaction, causes eye irritation, and to seek medical attention if symptoms occur from swallowing, inhalation, or skin contact. OXYGEN STORAGE On March 24, 2025, at 9:37 a.m., during facility tour with LALD-A, the surveyor observed R3's apartment door opened and located inside R3's door was one unsecured tall oxygen cylinder tank. On March 25, 2025, at 6:19 a.m., the surveyor observed R3's apartment door opened and located inside R3's door was one unsecured tall oxygen cylinder tank. On March 25, 2025, at 9:09 a.m., CNS-C and the surveyor observed R3's apartment door opened, and located inside R3's door was one unsecured tall oxygen cylinder tank. CNS-C stated the licensee was not aware an oxygen cylinder tank was delivered to R3, since the licensee did not contact the oxygen management company for an oxygen cylinder tank, and hospice must have	02310		

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02310	Continued From page 22 placed the order for R3 to receive an oxygen cylinder tank. CNS-C further stated oxygen cylinder tanks were stored securely in a rack when the licensee had any oxygen cylinder tanks onsite. Registered nurse (RN)-B further stated the licensee sent all oxygen tank racks back to the oxygen supplier due to no oxygen cylinder tanks onsite. The licensee's Safe Oxygen Use and Storage policy dated December 3, 2021, indicated oxygen containers (oxygen cylinder tanks) must be secured in a stand or cart so they (oxygen cylinder tanks) cannot be knocked over while in use or in storage. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and	02410		

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02410	Continued From page 23 seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of two residents (R8) during medication management services in a nonprivate area. 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:	02410		

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02410	Continued From page 24 During the entrance on March 24, 2025, at 9:15 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to residents at the facility. On March 25, 2025, at 9:03 a.m., the surveyor observed R8 sitting at a dining room table with two other residents. The surveyor observed unlicensed personnel (ULP)-G place one eye drop in each of R8's eyes, ULP-G handed R8 the nasal spray, R8 self-administered two sprays in each nostril, and ULP-G then administered R8's oral medications. The surveyor did not observe ULP-G offer to move R8 to a private area or to R8's room prior to medication administration. In addition, the surveyor did not observe ULP-G ask the two other residents at the table if they were comfortable with having the eye drops and nasal spray administered to R8 at the dining room table. On March 25, 2025, at 10:37 a.m., ULP-H stated residents were supposed to be brought to a private area prior to medication administration. On March 25, 2025, at 10:40 a.m., ULP-D stated ULPs were supposed to have residents move to a private area or to the resident's room for privacy for any medication administration that was not an oral (by mouth) medication. On March 25, 2025, at 10:50 a.m., ULP-G stated ULP-G had known R8's preference was having eye drops and nasal spray being administered at the table. On March 25, 2025, at 3:13 p.m., CNS-C stated all non-oral medications were supposed to be administered in a private area and not at the dining room table. CNS-C further stated ULPs	02410		

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02410	Continued From page 25 were trained to offer a resident more privacy prior to any medication administration. The licensee's Delegation of Nursing Tasks dated October 27, 2021, indicated the registered nurse (RN) must instruct the ULP in the proper methods to provide the treatment or perform the task with respect to each resident and determine that the ULP has demonstrated the ability to competently follow the procedures. In addition, the RN communicated with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

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

Type: Full
Date: *03/24/25*
Time: 14:03:48
Report: 7935251046

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.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST NEW CERTIFICATE. EXPIRED CERTIFICATE WAS POSTED.

Comply By: 04/11/25

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

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

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

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 34 Degrees Fahrenheit - Location: Walk In Cooler
Violation Issued: No

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

Type: Full
Date: *03/24/25*
Time: 14:03:48
Report: 7935251046
Riverfront On Main

Food and Beverage Establishment Inspection Report

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

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 7935251046 of 03/24/25.

Certified Food Protection Manager: Christopher Friday

Certification Number: 332293 Expires: 02/14/27

Signed: _____
Establishment Representative

Signed: Rebecca Tonneson
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us