DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2020

Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, MN 55744

RE: CCN: 245368
Cycle Start Date: October 20, 2020

Dear Administrator:

On November 23, 2020, we notified you a remedy was imposed. On December 7, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 4, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 8, 2020 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 8, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 8, 2020 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 4, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 9, 2020

Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

RE: CCN: 245251
Cycle Start Date: October 22, 2020

Dear Administrator:

On October 22, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 22, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 22, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245251	A. BUILDING _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/20/20, through 10/22/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5251027C, H5251028C, H5251029C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop individualized interventions to address exhibited behaviors of dementia for 2	F 744	The facility ensures dementia residents receive the appropriate monitoring for safety related to the supervision of wandering behaviors.	12/16/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/18/2020

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F 744	Continued From page 1 of 3 residents (R1, R2), observed to wander and enter the rooms of other residents. Findings include: R1's admission Minimum Data Set (MDS) dated 7/31/20, indicated R1 had severely impaired cognition, demonstrated short tempered behavior, physical symptoms toward others daily, and wandered daily. R1 required extensive assistance with most activities of daily living (ADL's). Diagnosis included Alzheimer disease, anxiety, and a recent urinary tract infection. R1's Care Area Assessments (CAAs) triggered on 7/31/20, included cognitive loss/dementia, psychosocial well-being, behavioral symptoms, and activities. R1's Activity CAA dated 8/5/20, indicated R1 was invited to activities, but did not actively participate and would stand up and walk away. R1's admission activity assessment dated 8/11/20, indicated family involvement, snacks, listening to music, and going outside were important daily preferences. The assessment indicated R1 interests included sewing, cooking, baking, caring for plants, and word searches. R1's care plan reviewed 8/7/20, indicated R1 had impaired cognitive loss/dementia and wandered. Staff were directed to approach resident from front and walk in step with resident before redirecting, develop a pathway for resident to follow, and keep pathway free of obstacles. Staff were also directed to follow familiar routines, maintain a calm environment and approach to resident, provide visual deterrents such as stop signs at other resident doors, remove resident	F 744	It was identified that 5 residents have the potential to be affected by future deficient practices. Wandering and behaviors of residents will be comprehensively assessed through the IDT. Through the comprehensive assessment, interventions to mitigate wandering will be put in place. A comprehensive assessment was completed on R1 on 11/19/2020 to identify behaviors related to wandering. Through the comprehensive assessment it was identified that the following interventions would be appropriate to decrease wandering without purpose for R1. On 10/16/2020 resident was assessed through labs for reasons for aggression. On 10/30/2020 a Rummage Room was created to allow for R1 to safely rummage and hoard without disrupting other resident rooms. On 11/12/2020 a wander guard system was put in place to notify staff when R1 is wandering near R5□s room where she can be redirected to another activity. On 11/13/2020 it was implemented that resident would be offered an iPod shuffle for music therapy after needs have been met and continues to display signs of anxiousness and wandering. R1 has the potential to wander unsafely into other resident rooms becoming aggressive when frustrated. On 10/15/2020 resident was put on 30 minute safety checks to ensure resident was not wandering unsafely and needs are met.	

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F 744	Continued From page 2 from other resident's rooms and unsafe situations when possible. Additions made to care plan on 10/16/20, included 30 minute rounding with resident to ensure needs were met, redirect to other areas if needed, assess whether the behavior endangered the resident and/or others and intervene if necessary, and to follow familiar routines, such as frequent snacks as needed. R1's care plan lacked an activity problem to address goals and approaches to satisfy R1's activity needs. R1's care plan failed to incorporate R1's identified interests and preferences. On 10/20/20, at 4:45 p.m. R1 was observed to wander in the hallways. -At 5:03 p.m. nursing assistant (NA)-A was observed to be walking along side R1 as she continued to wander through the hallways of the facility. NA-A was observed to redirect R1 whenever she tried to enter the 600 resident hallway. NA-A would turn R1 around and had her go back to her own hall, the 700 hall. -At 5:16 p.m. R1 was observed to continue to wander the halls with nearly constant 1:1 staff, who redirected R1 away from the 600 hall whenever she attempted to go down there. On 10/22/20, at 9:00 a.m. R1 was observed to start wandering in the resident hallway and was redirected by the administrator to sit in a recliner in the commons area. -At 9:15 a.m. a current events activity was conducted in the commons area, four residents were observed to attend and discussed news events and stories with the activity aide (AA)-A. R1 was observed seated in the commons area sleeping and did not participate in the activity.	F 744	The comprehensive assessment also identified that the resident becomes aggressive when startled by either staff or residents. This is inclusive of residents or staff approaching her from behind, approaching her quickly from the front, or using a loud voice. In the comprehensive assessment it was identified that R1 tends to wander most often in the late afternoon, early evenings. If resident is unable to be redirected under proper supervision at any point during the day, resident will be placed on 1:1 at the discretion of the charge nurse until deemed safe to return to 30 minute checks. This was care planned on 11/20/2020. The comprehensive assessment review of R1 also identified that R5 does not like have individuals enter her room without her permission, including those wandering. A stop sign is in place and the door to the resident□s room will remain closed when resident permits it to be. This was care planned 10/17/2020. On 11/9/2020 resident was seen by her psychiatrist whom recommended adding Celexa 5 mg PO daily and Risperdal .25 mg BID PRN to her medication regimen. R1 continues to be followed by psychiatry. R1 does receive the appropriate monitoring for safety, related to the supervision of wandering behaviors. A comprehensive assessment was completed on R2 on 11/19/2020 to identify reasons related to wandering. In the	

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F 744	Continued From page 3 Progress notes indicated the following: On 9/27/20, at 11:24 p.m. R1 wandered all evening in the hallways and in other's rooms. At 9:25 p.m. staff heard a scream coming from the 600 wing. On investigation, R1 was observed coming out of another resident's room. R1 was redirected and given a snack. R1 was also given a snack prior to this and was given another snack, when she started to wander again after cares. On 9/28/20, at 2:30 p.m. R1 was found coming out of another resident's room. The other resident was screaming and standing in his doorway. On 10/8/20, at 6:55 p.m. R1 entered R4's room, where the resident and his spouse were seated. R1 was trying to rummage through the resident's closet and take out clothes when R4's spouse attempted to intervene. R1 hit the spouse on her right shoulder. There was no visible injury. On 10/10/20, at 5:11 p.m. R1 wandered into R4's room, where the resident and his spouse were seated. R1 raised her arm angrily toward R4's spouse, causing the spouse to run outside of the room, away from R1. R1 had been ambulating all day wandering into other resident's rooms and grabbing belongings. On 10/12/20, at 3:30 p.m. R1 wandered and rummaged through the unit after supper. R1 had a package of wipes and when staff attempted to remove them from her hands, R1 began charging at the staff member, trying to grab them. Staff was able to be redirect R1 within a minute of the behavior. R1 had a snack and has been resting in bed. On 10/13/20, at 8:22 a.m. a new order from the primary care provider was received to increase	F 744	comprehensive assessment it was identified that the following interventions would be appropriate to decrease wandering without purpose for R2. R2 frequently declines attendance at group activities. R2 will be offered additional opportunities for socialization. This was care planned on 11/2/2020. The comprehensive assessment also revealed that R2 has identified the following interests as highly important in the past baking, church, current events, music, socialization, children, and pets. R2 has been reassessed for activity interests and still identified the above items as highly important, however, refuses to take part in activities related to these items. R2□s preferences will continued to be assessed quarterly for changes in interest. On 11/20/2020 it was care planned that resident will be encouraged to participate in group activities by being invited by another trusted resident or staff member to encourage participation. R2 was medically cleared on 9/1/2020. Request has been sent to R2□s MD for another lab workup. R2 continues to be followed by psychiatry. R2 had Trazadone 50 mg QHS started on 8/17/2020 due to bipolar disorder. R2 was d/ced off of Trazadone due to a decrease in behaviors on 10/16/2020 and was restarted on 11/2/2020 d/t increase in behaviors and was considered a failed GDR. No non-pharmacological	

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F 744	Continued From page 4 Risperidone (an antipsychotic medication). R1's power of attorney (POA) was updated, and refused the increase of medication at this time. On 10/14/20, at 12:06 a.m. R1 wandered all evening, in others rooms and down the 600 wing. R1 wandered into R5's room. R5 screamed out for help. Staff redirected R1 back to common area, and R1 was given a snack. R1 sat for 45 minutes, then continued to wander and required redirection away from the 600 wing. On 10/14/20, at 6:35 p.m. R1 grabbed another resident's drink, and when staff attempted to intervene, became agitated and was hitting staff. On 10/15/20, at 5:28 p.m. R1 entered R5's room and grabbed R5's arm, leaving bruises. On 10/15/20, at 6:07 p.m. an intervention was placed to round on R1 every 30 minutes. R1's medical record was reviewed and lacked any evidence of interventions and approaches to attempt to reduce R1's demonstrated behaviors of wandering and entering others rooms. On 10/21/20, at 9:54 a.m. R5 was interviewed. R5 displayed a dark bruise on her left forearm, and stated R1 had grabbed her, causing the bruise. R5 stated she was frightened of R1, and she felt the facility had not "done a hell of a lot" to keep R1 from bothering her. R5 stated the stop signs and Velcro stop banners did not do anything to keep R1 from entering others rooms. R5 stated R1 would just tear them down. On 10/21/20, at 10:22 a.m. AA-A was interviewed and stated R1 liked to wander and would grab things out of others rooms. AA-A stated R1 did not respect the stop signs, and you could sometimes find R1 wandering with her arms full of the Velcro signs.	F 744	interventions were successful at that time. In the comprehensive assessment it was identified that R2 tends to wander most often in the afternoon, early evenings. If resident is unable to be redirected under proper supervision at any point during the day, resident will be placed on 1:1 at the discretion of the charge nurse. This was care planned on 11/20/2020. Staff have been in-serviced on proper monitoring for safety related to the supervision of wandering behaviors, anger and aggression related to dementia, and rummaging and hoarding related to dementia by 11/23/2020. The in-service will cover the expectations for 1:1 and 30 minute checks and that 1:1 and 30 minute checks will only be discontinued when decided by the IDT. The Admin/DON/Designee will do observations at least 2x week, with residents known to be on 30 minute checks to verify that the supervision is being provided as stated. Non-compliance will result in re-education or disciplinary action. The Activities Director will audit activity participation of R1 and R2 1x weekly for four consecutive weeks to ensure that care planned activities are meaningful and successful for the identified residents. The Activities Director will reassess R1 or R2 is activities prove to be unsuccessful in resident participation or for redirection of resident.	

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F 744	Continued From page 5 On 10/21/20, at 1:49 p.m. NA-B was interviewed and stated R1 wandered in and out of others rooms and rummaged. NA-B stated staff would take R1 by the hand and try to redirect her. NA-B stated staff would offer diversional things such as a snack. NA-B stated staff knew what interventions to try, because staff worked with the wandering residents a lot and got to know them, and it was in their care plan. NA-B stated if there was a new approach, the staff would hear about it in report. On 10/22/20, at 10:47 a.m. AA-B was interviewed and stated activities had started an activity binder that went into detail of resident likes and dislikes. AA-B stated R1 was more one to one with activities. AA-A stated she would get a watering can and water the plants with R1, and R1 would put her finger in the soil to see if it was wet. When R1 was wandering, staff would take her hand and visit with her, and gently try to lead her back to the commons area. On 10/21/20, at 4:19 p.m. the director of nursing (DON) stated she was aware of the incident between R1 and R5, and that a vulnerable adult report had been filed regarding the incident. The DON stated she was not in charge of doing the investigations for incidents, rather the social services designee/activity director (AD)-A investigated the incidents. The DON stated she was not aware R5 had stated she was frightened of R1. The DON stated the family refused to increase R1's antipsychotic medication, so a middle ground was reached to draw labs to see if anything was going on acutely medical with R1. The DON stated R1 was a tougher one to find diversional activities for, and was frequently	F 744	The DON/Designee will report all findings to the QA/QAPI committee monthly. After 6 months if the threshold of 95% or greater hasn□t been achieved, the facility will continue to monitor until the threshold is reached.	

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F 744	Continued From page 6	F 744		

uninterested and just wanted to walk. The DON stated R1 liked to walk down the 600 unit to try to exit seek. The staff would try to intervene before she got to the exit doors at the end of the 600 unit, as R1 would become frustrated because she could not get out.

On 10/22/20, at 1:46 p.m. in a joint interview with the DON and AD-A, who was on speaker phone, AD-A stated R1 was admitted in July, 2020, however, there was not an activity problem addressed on her care plan. AD-A stated she was working on a paper document care plan for R1, but had not inputted it into the electronic record and it was not available to other staff. The DON stated the staff felt hunger to be a driving factor for R1 to wander into others rooms, so they took snack foods out of others rooms and offered snacks to R1 for diversional activity. The DON stated there was not an activity to offer R1 to occupy her when she began to wander. AD-A stated R1 was kind of like a shopper, she would rummage through others rooms, and R1 would gather stop signs and carry them around with her. AD-A stated she was thinking of ideas to implement, to satisfy that need, however, had not implemented any interventions as of yet. AD-A stated she was working on trying to get approaches and interventions more individualized, which was why she had the activity aides filling out personalized intake forms on the residents, but had not implemented any in the plan of care, as it was still a work in progress.

R2's annual MDS dated 9/22/20, indicated R2 was severely cognitively impaired, demonstrated physical and verbal behaviors as well as other physical behavioral symptoms toward others and wandered daily. R2 required extensive assist with

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most ADLs. R2's diagnoses included Alzheimer's disease, anxiety, restlessness, and agitation.

R2's behavior CAA dated 9/27/20, indicated R2 continued to have multiple behaviors of wandering into others rooms and moving their personal items, was resistive with personal cares, and would hit out at staff.

R2's care plan dated 10/5/20, indicated R2 had socially inappropriate, and had disruptive behavioral symptoms of rummaging thorough and taking resident items, taunting other peers, and disrupting other's routines. Staff were directed to allow distance in seating other residents in dining room, contact primary care physician when resident was having non-redirectable behaviors, assess whether the behaviors endanger the resident or others, and intervene if necessary. Staff were also directed to divert resident's behaviors by offering more snacks, curling hair, giving a baby doll, giving imitation money, and providing one to one visits. Staff were directed to remove R2 from other resident's rooms and unsafe situations when deemed necessary. When R2 became socially disruptive, staff were to provide comfort measures for basic needs. Additions made to the care plan on 10/22/20, directed staff to provide consistency in allowing R2 to rest in peer's beds, when appropriate. The care plan indicated this should be avoided with peers that have stop sign on door/doorway, and when peers were in their designated rooms. When wandering, staff were to remove R2 from other resident rooms before potential unsafe situations. R2's care plan indicated R2 had a variety of activity interests, did not object to group activity, and benefited from weekly one to one visits. R2 enjoyed talking and conversing with

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	245251	A. BUILDING _____ B. WING _____	C 10/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HOSPITAL & NURSING HOME	**323 SOUTH MINNESOTA CROOKSTON, MN 56716**

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visitors, staff, and peers, and benefited from opportunities to socialize. The care plan directed staff to engage R2 in one to one visits, invite, encourage, and assist to programs of interest, and introduce and promote conversation with other residents.

On 10/21/20, at 9:10 a.m. R2 was observed to ambulate into another resident's unoccupied room and lie on the resident's bed.
At 11:14 a.m. R2 was observed to be ambulating in the facility hallways. R2 attempted to ambulate down the facility's 600 wing. An unidentified NA attempted to redirect R2 to turn around and go back to her own 700 wing. R2 became agitated, hollering, "Get away from me." The unidentified NA requested assist from another unidentified staff member, who was able to walk along with R2 down the hall, and eventually turn and return R2 to the 700 wing.
At 11:36 a.m. R2 was observed to continue to wander up and down the 600 wing of the facility with one to one staff walking with her.
At 2:25 p.m. R2 was not observed in her room. R2 was not found in any other common areas or resident rooms.
At 2:45 p.m. NA-B stated she did not know where R2 was. NA-B and NA-C started to actively search resident rooms and the facility to locate R2. NA-B and NA-C then asked the administrator and the DON if they had seen R2. The administrator and the DON started to search resident rooms, and the facility to locate R2.
At 2:51 p.m. R2 was found by an unidentified NA in a closed off wing of the facility. Licensed practical nurse (LPN)-A stated the doors were closed, but unlocked due to fire codes. There were two empty resident rooms, a utility closet, and a secured exit door located in the closed off

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wing.

On 10/22/20, at 11:04 a.m. R2 was observed going in and out of other resident rooms. Staff were assisting other residents and did not intervene.
At 2:00 p.m. R2 was observed to forcefully open a closed resident room door, followed closely by an unidentified NA. The NA was attempting to stop R2. R2 immediately went into the room's bathroom and used the toilet. R2 did not respond to the NA's redirection attempts. R2 refused to wash her hands after toileting and left the room, followed by the unidentified NA.

Progress notes indicated the following:

On 10/15/20, at 7:20 p.m. R2 was agitated and wandering into others rooms. When redirected, R2 would state the room was hers.
On 10/16/20, at 2:43 p.m. R2 was wandering into other's rooms, and was difficult to redirect. R2 would swat at staff and swear at staff.
On 10/17/20, at 12:45 a.m. R2 was wandering through out the evening.
On 10/17/20, at 1:25 p.m. R2 was wandering into other resident's rooms, despite doors being closed and stop signs on doors. R2 would verbally and physically act out at staff when staff attempted to redirect from other resident rooms. R2 did not respond despite staff redirection
On 10/18/20, at 2:28 p.m. R2 wandered into the 600 wing of the facility, and would lie in others beds. R2 became physically combative when staff attempted to redirect her. Three staff members were needed to remove R2 from the 600 wing, back to her 700 wing.
On 10/19/20, at 12:37 a.m. R2 wandered in and out of others rooms through out the evening shift.

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On 10/19/20, at 5:24 p.m. staff administered an as needed antipsychotic medication intramuscularly for behavioral symptoms.
On 10/20/20, at 12:17 a.m. R2 wandered in and out of others rooms through out the evening shift, and was difficult to redirect.
On dated 10/20/20, at 5:55 p.m. R2 wandered in and out of others rooms, and hit out at staff with redirection. R2 rested in another resident's bed for almost an hour before staff was able to successfully redirect her.

On 10/21/20, at 1:30 p.m. LPN-A was interviewed and stated R2 could get possessive over other's belongings and aggressive with staff, but it was uncommon for R2 to have resident to resident altercations.

On 10/21/20, at 2:24 p.m. family member (FM)-A stated R2 came into her mother's room often, but staff usually intervened quickly.

On 10/21/20, at 4:19 p.m. The DON stated R2 was busy, and her activity level would go in spurts. The DON stated R2 was not on any specific rounding schedule, but staff usually round every two hours. The DON stated the doors that separated the small area R2 had entered when staff were unable to find R2, had been removed. The DON stated staff would allow R2 to sleep in other's beds, and would keep an eye on R2 as well as for the resident whose bed it was. Staff would intervene if observed the other resident going into their room, and remove R2 from the bed at that point. The stop signs on certain resident doors was to alert staff that R2 should not be going into that room. The DON was unable to find an activity calendar that listed the resident's weekly activity schedule. The DON

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stated the activity director was currently out, so an activity calendar had not been posted for the week requested. The DON stated the activity director was responsible for investigating the incident reports, but they were reviewed at interdisciplinary team meetings weekly.

On 10/22/20, at 1:46 p.m. during a telephone interview, AD-A stated R2 enjoyed an electronic baby as a diversional activity, but did not like more hands on activity. AD-A stated working with resident personal interests was something the activity program needed to work on. AD-A stated she was trying to work on personal interest forms to gain a deeper understanding, and was working on trying to get meaningful and purposeful activities implemented and working in the facility.

The facility policy Riverview Care Center Activity dated 7/2/20, directed it was the facility's policy to provide an ongoing program to support resident in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident as well as, encourage both independence and interaction within the community. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. These include considerations for residents who exhibit unusual amounts of energy or walking without purpose, engage in behaviors not conductive with therapeutic home like environment, residents who go through others' belongings, and residents who lack awareness of personal safety.

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F 744	Continued From page 12 The facility policy Riverview Care Center Behavioral dated 8/23/20, directed all residents receive behavioral health care and services to assist him/her to reach and maintain the highest level of mental and psychosocial functions. Guidelines directed staff to include the resident and family in the comprehensive assessment process along with the interdisciplinary team and outside sources as appropriate. The policy directed staff, the care plan should be person-centered, provide for meaningful activities which promote engagement and positive meaningful relationships, reflect the resident's goals for care, account for the resident's experiences and preferences and maximize the resident's dignity, autonomy, privacy , socialization, independence, and safety.	F 744		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 9, 2020

Administrator
Riverview Hospital & Nursing Home
323 South Minnesota
Crookston, MN 56716

Re: Event ID: HQDX11

Dear Administrator:

The above facility survey was completed on October 22, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

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	00470	A. BUILDING: _____ B. WING _____	C 10/22/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/20/20, to 10/22/20, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/20

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2 000	Continued From page 1 The following complaints were found to be substantiated: H5251027C, H5251028C, H5251029C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		