Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306465503M
Compliance #: HL306462777C

Date Concluded: October 31, 2025

Name, Address, and County of Licensee Investigated:
River Pointe of Moorhead
2401 11th Street South
Moorhead, MN 56560
Clay County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the resident choked on food and passed away at the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident choked resulting in death, the resident's plan of care was followed at the time of the incident. When the resident was found slumped over in her chair after choking, facility staff provided immediate assistance and contacted emergency medical services. The resident died at the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care provider (PCP) and the speech language pathologist (SLP). The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, staff schedules,

law enforcement reports, and related facility policy and procedures. Also, the investigator observed meal service at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included myotonic muscular dystrophy (a genetic disorder of progressive muscle weakness) and dysphagia (difficulty swallowing). The resident's service plan included assistance including dressing, grooming, toileting, and medication administration. The resident's assessment indicated the resident could eat independently and did not need assistance. The resident did not have any dietary restrictions and had a normal diet with thin liquids. The resident's assessment indicated the resident was cognitively intact and able to make her needs known.

The facility's internal investigation indicated another resident sitting at the table with the resident stated the resident was eating her hamburger and kind of "ahemmed" and put her hand up like she does sometimes when she has a hard time swallowing. They asked the resident if she was ok and she shook her head yes, they asked again if she needed help, and she shook her head yes. Another resident pressed the resident's call pendant and went to find a staff member.

Emergency medical services (EMS) reports indicated the resident was found unresponsive, and EMS provided chest compressions and removed a large amount of debris. When the resident arrived at the hospital lifesaving efforts were stopped and the resident passed away. Facility staff told EMS the resident had a history of choking, but the incidents had not been as bad as this one.

Review of medical records indicated the resident had a history of choking. The resident was seen by her medical provider and speech therapist regarding concerns. Recommendations were provided to the resident to prevent choking. The resident acknowledged the recommendations and remained independent with eating. The resident was ordered a normal diet when the incident occurred.

During an interview, a facility staff stated he was aware the resident had a history of choking but was not aware of any restrictions she had. The day of the incident a facility staff responded to the dining room after the emergency pull cord was activated and when he arrived there was a dietary staff member there already. A facility staff stated the resident kept bobbing forward so he tried to help hold her in her wheelchair until the nurse arrived.

During an interview, a resident who witnessed the incident stated the resident had some issues with choking due to her diagnosis. The resident stated there had been a few times in the past when the resident would start choking on food and the resident had been told to raise her hands above her head so it would clear the food.

During an interview, a facility nurse stated the resident didn't have any dietary restrictions. The resident wanted to make her own food decision so she'd order off the menu things she wanted

to eat and would take smaller bites, cut them up, or take longer to chew things, and if she knew there were things she couldn't eat, she'd not eat those things. The nurse stated the resident had prior choking incidents in the dining room where she'd cough on different textures of food, but she'd be able to clear it on her own by putting her hands up in the air. The nurse stated the resident knew the risks and wanted to keep eating what she wanted to eat and make those choices independently.

The resident's primary care provider stated the resident was well informed of her diagnosis and her disease process could lead to choking.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility investigated the incident and reported it to MAARC.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30646	A. BUILDING: _____ B. WING _____	C 09/11/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On September 11, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL306465503M/ #HL306462777C. No correction orders are issued.	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.	