Electronically Delivered

January 17, 2025

Licensee
Vista Prairie At Windmill Ponds Memory Care
803 Victor Street
Alexandria, MN 56308

RE: Project Number(s) SL26046016

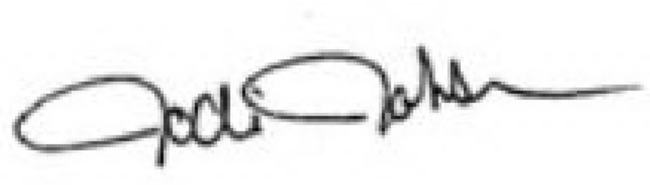
Dear Licensee:

On January 2, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the October 23, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Electronically Delivered

December 3, 2024

Licensee
Vista Prairie At Windmill Ponds Memory Care
803 Victor Street
Alexandria, MN 56308

RE: Project Number(s) SL26046016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 23, 2024, 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.

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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at

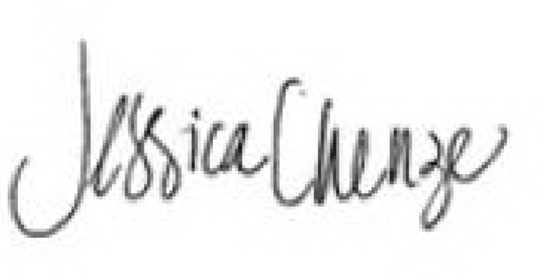
the website listed above.

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26046	A. BUILDING: _____ B. WING _____	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT WINDMILL PONDS MEMOR'	803 VICTOR STREET ALEXANDRIA, MN 56308

(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: SL26046016-0 On October 21, 2024, through October 23, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 16 residents; 16 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on October 22, 2024, issued for SL26046016-0, tag identification 2070. On October 22, 2024, at 2:24 p.m., the licensee provided actions to the surveyor supervisor to mitigate the immediacy of correction order 2070, however, non-compliance remained at a scope and level of I.	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.	
0 330 SS=E	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide	0 330		

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0 330	Continued From page 1 accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide accurate and truthful information for one of one resident (R3). In addition, the licensee failed to provide an accurate revised staffing plan based on census changes for the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION DESTRUCTION During the entrance conference on October 21, 2024, at 10:07 a.m., registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility. The licensee's Discharged or Deceased Resident Roster: State Evaluations dated October 21, 2024, indicated R3 was admitted to the licensee on July 1, 2024, and was discharged from the licensee on October 5, 2024.	0 330		

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0 330	Continued From page 2 R3's diagnoses included pancreatic cancer, congestive heart failure (CHF), and seizure disorder. R3's Service Plan dated October 22, 2024 (one day after the initiation of the survey), did not indicate services provided to R3 and was not authenticated by R3, R3's representative, or the licensee. R3's prescriber orders dated September 24, 2024, included an order for lorazepam 2 milligrams (mg)/milliliter (mL)- give 0.25 mL by mouth every three hours as needed (PRN) for anxiety or restlessness. On October 22, 2024, at 7:57 a.m., the surveyor reviewed the medication refrigerator located in the nurse's office on the Lake Henry unit with clinical nurse supervisor (CNS)-B and observed 20 syringes of lorazepam 2 mg/mL- 0.25 mL of liquid in each syringe. CNS-B stated the syringes of lorazepam were for R3 who had been discharged, however, had not been destructed since CNS-B needed an additional licensed nurse to be involved in the destruction of lorazepam. R3's record contained an Individual Narcotic Record page 82 dated October 2024, for lorazepam 2 mg/mL, which indicated 20 syringes of 0.25 mL lorazepam 2 mg/mL were destroyed via drug buster by CNS-B and RN-C on October 8, 2024 (14 days prior to the observation of R3's 20 syringes of lorazepam in the medication refrigerator). On October 23, 2024, at 1:23 p.m., CNS-B stated R3's lorazepam was not destructed on October 8, 2024, and CNS-B and RN-C destructed the lorazepam yesterday (October 22, 2024) after the surveyor requested to review R3's discharge record. The licensee's Disposition or Disposal of Medication policy dated August 1, 2021, indicated upon destruction of the medication the	0 330		

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0 330	Continued From page 3	0 330		

documentation would include the date of destruction.
STAFFING PLAN
The licensee held an Assisted Living with Dementia Care license with a capacity of 26 residents and had a current census of 16 residents.
During the entrance conference on October 21, 2024, at 10:02 a.m., registered nurse (RN)-C stated the licensee was familiar with current minimum assisted living requirements.
The licensee's Discharged or Deceased Resident Roster: State Evaluations dated October 21, 2024, indicated the licensee had discharged seven residents from July 7, 2024, through October 10, 2024.
The licensee's Current Resident Roster: State Evaluations dated October 21, 2024, indicated the licensee had admitted an additional two residents after July 1, 2024, on September 4, 2024, and September 30, 2024, respectively.
The licensee's Direct-Care Staffing Plan dated June 28, 2024, indicated based on number of residents the day shift (6:00 a.m. to 2:00 p.m.) should be covered with four unlicensed personnel (ULPs), the evening shift (2:00 p.m. to 10:00 p.m.) should be covered with two ULPs, the evening shift (2:00 p.m. to 8:30 p.m.) should be covered with two ULPs, the night shift (10:00 p.m. to 6:00 a.m.) should be covered with one ULP at the "Care Suites" (Lake Henry and Lake Agnes units), and one ULP at the assisted living (building across the street owned by the same company) effective July 1, 2024. In addition, when residents require a two-person assist there will be a minimum of two staff available at all times and there will be 24-hour, awake staff available to respond to resident requests for assistance with health and safety needs.
On October 21, 2024, at 12:21 p.m., RN-C

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0 330	Continued From page 4 stated, "Who gave you (surveyor) this staffing plan?" RN further stated the staffing plan provided was not correct and the licensee had three ULPs working on each day shift, three ULPs working on each evening shift, and two ULPs working on each night shift. The licensee's Direct-Care Staffing Plan dated October 21, 2024 (date of survey entrance), indicated based on number of residents the day shift (6:00 a.m. to 2:00 p.m.) should be covered with three ULPs, the evening shift (2:00 p.m. to 10:00 p.m.) should be covered with two ULPs, the evening shift (5:00 p.m. to 10:00 p.m.) should be covered with one ULP, the night shift (10:00 p.m. to 6:00 a.m.) should be covered with two ULPs effective July 1, 2024 (same effective date as the Direct-Care Staffing Plan dated June 28, 2024). In addition, when residents require a two-person assist there will be a minimum of two staff available at all times and there will be 24-hour, awake staff available to respond to resident requests for assistance with health and safety needs. On October 22, 2024, at 2:11 p.m., RN-C stated the licensee had a meeting to update the staffing plan due to a census change on October 18, 2024, at 10:30 a.m., however, RN-C had not updated the staffing plan until October 21, 2024 (date of survey entrance), and RN-C had printed the wrong staffing plan provided to the surveyor. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated August 1, 2021, indicated the staffing plan will be evaluated for the appropriately [sic] of staffing levels in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330		

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0 480	Continued From page 5	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 21, 2024, 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. (13)(i)(A)and(C) Minimum Requirements	0 485		

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0 485	Continued From page 6 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) 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; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; 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:	0 485		

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0 485	Continued From page 7 During the entrance conference on October 21, 2024, at 10:08 a.m., registered nurse (RN)-C stated the licensee provided residents three meals per day, the licensee did not require a resident to pay for meals in the resident assisted living contract, and the meal plan offered to residents was all inclusive. On page five of the licensee's assisted living contract, Section one (1): indicated Housing Related Services included in the Monthly Rent: [licensee name] includes all basic housing services or amenities identified below in the month rent. b. Availability of Three (3) nutritious meals and one (1) snack per day. The licensee's Meal Program Addendum indicated to: Please select one of the following Meal Program [sic] options. -three (3) meals each day for _____ [sic]; or -no meal plan through [licensee name]. Resident assisted living contract addendums lacked an option for residents to opt out of payment for one or two meals residents would not want. On October 23, 2024, at 12:51 p.m., director of operations (DO)-K stated the licensee does not offer for residents to opt out of one or two meals the resident would not want, however, the licensee offered "a la cart" meal option to pay for meals as residents order them. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 15, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge.	0 485		

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0 485	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the	0 620		

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0 620	Continued From page 9 provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unaccounted narcotic loss from one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 620		

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	26046	A. BUILDING: _____ B. WING _____	10/23/2024

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0 620	Continued From page 10 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 21, 2024, at 10:12 a.m., registered nurse (RN)-C stated all narcotic medication was double locked in the medication carts and counted by two staff members at the end/start of each shift three times per day. The licensee's Discharged or Deceased Resident Roster: State Evaluations dated October 21, 2024, indicated the licensee admitted R1 on July 1, 2024, and R1 was discharged on September 20, 2024. R1's diagnoses included dementia, hypertension (HTN), and stage three chronic kidney disease. R1's Service Plan dated July 1, 2024, indicated R1 received medication management services to include medication administration. R1's Medication Management dated September 9, 2024, indicated medications were locked in the med (medication) cart as an intervention to prevent diversion of medication by the resident or others who may have access to medications. R1's prescriber orders dated July 16, 2024, included an order for lorazepam 0.5 milligram (mg) tablet to be administered by mouth at bedtime daily and every six hours as needed for anxiousness or restlessness effective June 11, 2024.	0 620		

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0 620	Continued From page 11 R1's Medication Incident Report dated July 14, 2024, at 11:00 p.m., indicated R1 had a missing lorazepam 0.5 mg pill. Clinical nurse supervisor (CNS)-B reported the missing lorazepam 0.5 mg pill to RN-C on July 15, 2024, at 9:00 a.m., and unlicensed personnel (ULP)-M and ULP-N denied signing off Ativan (lorazepam). ULP-M gave a lorazepam 0.5 mg at 7:35 p.m., but did not sign out an additional dose and still needed to contact ULP-O for ULP-O's testimony. RN-C documented on the incident investigation on July 15, 2024, at 11:37 a.m., and wrote system re-evaluated and corrections made, educated staff via discussion. R1's Progress Notes dated July 15, 2024, at 11:45 a.m., had the following entry written by RN-C: At med (medication) count this morning there is a missing medication on Agnes (Lake Agnes unit). We (licensee) are investigating this. Going forward you must adhere to the following: -All controlled substances must be initialed off on the card by two staff; -Under no circumstances will a scheduled or PRN (as needed) controlled substance be given by one staff person; -Two staff must go in to the resident and watch the medication being swallowed; and -This is serious and an ongoing investigation. My (RN-C) expectation is that all staff working memory care (dementia care unit) must give a thumbs up that they (staff) read this instruction. Thank you. On October 22, 2024 (after survey initiation), at 2:50 p.m., R1's incident investigation was updated by RN-C and RN-C wrote ULP-O's testimony stated resident's count was off and ULP-O was to speak with AM (morning) staff and	0 620		

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0 620	Continued From page 12 nursing about this correction. Narc (narcotic) book corrected due to verbal ability to reason why this (R1's lorazepam) count was off. R1's Medication Administration Record (MAR) dated July 2024, had documentation R1 received lorazepam 0.5 mg one tablet given by mouth each night from July 10, 2024, through July 14, 2024, and no additional lorazepam 0.5 mg tablets were administered from July 10, 2024, through July 15, 2024. R1's Individual Narcotic Record page 16 listed the following entries for lorazepam 0.5 mg take one tablet by mouth at bedtime and every eight hours [sic]: -July 10, 2024, at 7:20 p.m., one lorazepam 0.5 mg tablet was signed out by two staff members and 27 lorazepam tablets remained; -July 11, 2024, at 8:00 p.m., one lorazepam 0.5 mg tablet was signed out by two staff members and 26 lorazepam tablets remained; -July 12, 2024, at 7:20 p.m., one lorazepam 0.5 mg tablet was signed out by two staff members and 25 lorazepam tablets remained; -July 13, 2024, at 7:25 p.m., one lorazepam 0.5 mg tablet was signed out by two staff members and 24 lorazepam tablets remained; -July 14, 2024, at 7:25 p.m., one lorazepam 0.5 mg tablet was signed out by two staff members and 23 lorazepam tablets remained; and -July 15, 2024, at 9:30 a.m., CNS-B and RN-C documented 22 lorazepam tablets remained after investigation, however, R1's MAR dated July 2024 did not have documentation of an additional dose of lorazepam 0.5 mg tablet being administered after 7:25 p.m. on July 14, 2024. The licensee lacked documentation of a MAARC report for R1's lorazepam 0.5 mg tablet that was	0 620		

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0 620	Continued From page 13 discovered to be missing between July 14, 2024, at 7:25 p.m. through July 15, 2024, at 9:30 a.m. On October 22, 2024, at 1:56 p.m., RN-C stated the lorazepam 0.5 mg tablet was found and the licensee did not make a MAARC report. RN-C further stated R1's lorazepam count was off by one from evening staff that "forgot" to sign out the additional dose and RN-C never documented the follow up conversation with ULP-O. On October 23, 2024, at 1:08 p.m., RN-C stated the licensee tried to document the best the licensee could with what happened to R1's missing lorazepam 0.5 mg tablet since a ULP gave a dose of lorazepam 0.5 mg tablet, and the ULP forgot to sign it out of the narcotic logbook. RN-C further stated RN-C had reconciled R1's lorazepam 0.5 mg tablets with CNS-B on July 15, 2024, and the findings had satisfied the investigation, however, RN-C completed most of the investigation verbally and may have not documented the findings "clearly." The licensee's 7.07 Medication Loss or Spillage policy dated August 1, 2021, indicated in situations of known loss or unaccounted for prescription drugs a RN will investigate the situation, the investigation will be documented in required records, and any state or federal required action will be taken, if necessary. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 14 (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 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 interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all required content. This had the potential to affect all residents, staff, and visitors of the facility. 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	0 680		

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0 680	Continued From page 15 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 21, 2024, at 10:02 a.m., registered nurse (RN)-C stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP dated September 16, 2024, lacked required content to include a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy for this facility, however, the licensee's EPP for this facility referenced a sister facility's information. On October 23, 2024, at 1:02 p.m., director of operations (DO)-L stated the licensee had not updated the EPP to be specific to this assisted living facility regarding the facility's needs and its ability to provided assistance. The licensee's 9.01 EPP- Appendix Z Compliance policy dated August 1, 2021, indicated the EPP will include all required elements of appendix [sic] Z. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All	0 680		

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0 680	Continued From page 16 Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract.	0 900		

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0 900	Continued From page 17 Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of the assisted living contract. This had the potential to affect all current 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 the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 21, 2024, at 10:02 a.m., registered nurse (RN)-C stated the licensee was familiar with current minimum assisted living requirements. On September 26, 2024, at 11:13 a.m., the Office of Ombudsman for Long-Term Care sent an email (electronic mail), which indicated the licensee never sent an unsigned copy of the assisted living contract. R5 and R10's records included signed copies of an assisted living contract dated July 1, 2024. On October 23, 2024, at 12:47 p.m., director of operations (DO)-K stated a copy of the assisted living contract was submitted to the Office of	0 900		

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0 900	Continued From page 18 Ombudsman for Long-Term Care sometime before the licensee opened on July 1, 2024, and would have been sent sometime in June 2024. DO-K further stated DO-K would have to check with another management employee that would have submitted the assisted living contract to the Office of Ombudsman for Long-Term Care. Immediately following the interview, the surveyor requested to view documentation of the assisted living contract being sent to the Office of Ombudsman for Long-Term Care, however, the surveyor received no additional information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with	0 910		

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0 910	Continued From page 19 the required content for two of two residents (R5, R10). This had the potential to affect all residents who received assisted living services. 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 October 21, 2024, at 10:02 a.m., registered nurse (RN)-C stated the licensee was familiar with current minimum assisted living requirements. R5 and R10's Assisted Living Contract were signed on July 1, 2024. R5 and R10's assisted living contract did not include the provider's address, however, the assisted living contract listed a sister facility address that was located across the street. On October 23, 2024, at 12:48 p.m., director of operations (DO)-K stated the licensee updated the contract with the correct provider information when a resident moved into this specific provider location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		

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0 970	Continued From page 20	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. 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 include language waiving the facility's liability for health, safety, or personal property of a resident. 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 the potential to affect a large portion or all the residents). The findings include: During the entrance conference on October 21, 2024, at 10:02 a.m., registered nurse (RN)-C stated the licensee was familiar with current minimum assisted living requirements. The licensee's Assist Living Contract, provided to all residents, included the following clause that a resident would waive the facility's liability for	0 970		

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0 970	Continued From page 21 health, safety, or personal property of the resident: -page nine: 8. Resident Promise: p: Resident agrees to pay Provider for any loss or damage to the Apartment Unit [sic], building or grounds caused by the Resident ..., normal wear and tear excepted [sic]. On October 23, 2024, at 12:49 p.m., director of operations (DO)-L stated the licensee would request a resident reimburse for intended damaged property such as running an electric scooter in the wall. RN-B further stated the licensee provided a very generous amount of leeway when it comes to damages. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	01640		

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01640	Continued From page 22 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for one of two residents (R10) who had treatments or therapies managed by the licensee. 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: During the entrance conference on October 21, 2024, at 10:15 a.m., registered nurse (RN)-C stated the licensee provided treatment management services, including blood glucose checks (treatment to check level of sugar in the blood), to residents at the facility. R10's diagnoses included chronic obstructive pulmonary disease (COPD- difficult to breathe), diabetes, and hypertension (HTN-high blood pressure).	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26046	A. BUILDING: _____ B. WING _____	10/23/2024

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VISTA PRAIRIE AT WINDMILL PONDS MEMOR'	803 VICTOR STREET ALEXANDRIA, MN 56308

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01640	Continued From page 23 On October 22, 2024, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-G complete a scheduled blood glucose check for R10. R10's prescriber orders dated September 26, 2024, included an order to check blood sugar daily in the morning. R10's Assessment dated September 12, 2024, indicated R10 received blood glucose checks daily. R10's Service Plan dated July 1, 2024, lacked blood glucose checks daily. On October 23, 2024, at 1:34 p.m., RN-C stated R10's service plan did not list a blood glucose check daily since the licensee had blood glucose check listed as a medication order. RN-L further stated R10's service plan should have listed R10's blood glucose check daily in addition to having R10's blood glucose check as a medication order. The licensee's 7.05 Treatment and Therapy Management Plan policy dated August 2021, indicated for each resident at (licensee name) receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01710	Continued From page 24	01710		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) reassessed residents for appropriate medication management services when resident status changed for one of three residents (R11) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 21, 2024, at 10:07 a.m., registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility. R11's diagnoses included hypertension (HTN-high blood pressure), diabetes, and depression.	01710		

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01710	Continued From page 25 R11's unauthenticated Service Plan dated October 22, 2024, indicated R11 received medication management services to include medication administration. R11's record lacked a prescriber order for Refresh Tears. R11's Medication Management dated August 22, 2024, indicated resident ability to self-administer medications was not applicable, plan already in place for staff to administer medications and all medications were stored in a locked med (medication cart). On October 22, 2024, at 6:57 a.m., the surveyor observed unlicensed personnel (ULP)-G provide dressing and transfer assistance for R11. The surveyor observed a bottle of Refresh Tears on R11's counter located near R11's bathroom. ULP-G stated R11 self-administered Refresh Tears and stored the Refresh Tears bottle in R11's room. R11's record lacked evidence R11 was assessed for self-administration of Refresh Tears. In addition, R11's record lacked evidence R11 was assessed to store medications in R11's room. On October 23, 2024, at 1:16 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was not aware R11 had Refresh Tears in R11's room. RN-C stated it was not uncommon for resident's family to bring in over the counter medications and not inform the licensee. RN-C further stated it was expected for ULPs to notify nursing staff of medications observed in resident rooms, however, ULPs did not always know if a resident could self-administer over the counter medications.	01710		

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01710	Continued From page 26 The licensee's 7.03 Medication Management Individualized Plan policy dated August 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident. The individualized medication management record would include documentation of specific resident instructions relating to the administration of medications, and a description of storage of medications based on the resident's needs and preferences. The licensee's Storage of Medications policy dated August 1, 2021, indicated a RN must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or other considerations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730		

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01730	Continued From page 27 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all	01730		

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01730	Continued From page 28 required content for one of three residents (R11). 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: During the entrance conference on October 21, 2024, at 10:07 a.m., registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility. R11's diagnoses included hypertension (HTN-high blood pressure), diabetes, and depression. R11's unauthenticated Service Plan dated October 22, 2024, indicated R11 received medication management services to include medication administration. R11's record lacked a prescriber order for Refresh Tears. R11's Medication Management dated August 22, 2024, indicated clinical nurse supervisor (CNS)-B identified and reviewed all medications R11 was taking and completed medication reconciliation. On October 22, 2024, at 6:57 a.m., the surveyor observed unlicensed personnel (ULP)-G provide dressing and transfer assistance for R11. The surveyor observed a bottle of Refresh Tears on R11's counter located near R11's bathroom.	01730		

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01730	Continued From page 29 ULP-G stated R11 self-administered Refresh Tears and stored the Refresh Tears bottle in R11's room. R11's record lacked evidence of an updated medication reconciliation after R11 had begun using Refresh Tears. On October 23, 2024, at 1:16 p.m., clinical nurse supervisor (CNS)-B stated CNS-B was not aware R11 had Refresh Tears in R11's room. RN-C stated it was not uncommon for resident's family to bring in over the counter medications and not inform the licensee. RN-C further stated it is expected for ULPs to notify nursing staff of medications observed in resident rooms, however, ULPs do not always know if a resident can self-administer over the counter medications. The licensee's 7.03 Medication Management Individualized Plan dated August 2021, indicated medication management record will be current and updated when there are any changes and medication reconciliation will be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced	01880		

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01880	Continued From page 30 by: Based on observation, interview, and record review, the licensee failed to ensure one of one refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 21, 2024, at 10:07 a.m., registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility. On October 22, 2024, at 7:57 a.m., clinical nurse supervisor (CNS)-B stated the current temperature of the medication refrigerator was 34 degrees Fahrenheit (F) and the temperature of the medication refrigerator was documented in the logbook located in the kitchen. The surveyor observed the following medications in the medication refrigerator located in the nurse's office on the Lake Henry unit with CNS-B: -one unopened lorazepam (antianxiety) 2 milligrams (mg)/ milliliter (mL)- 30 mL bottle for R5 -20 syringes of lorazepam 2 mg/mL- 0.25 mL for R3 The (licensee name) Refrigerator/ Freezer Temp	01880		

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01880	Continued From page 31 (temperature) Log dated August 2024, September 2024, and October 2024, respectively, included a column to document the med (medication) refrig (refrigerator) daily. The medication refrigerator columns from August 1, 2024, through October 21, 2024, indicated the temperature of the medication refrigerator had been recorded two times out of the 82 opportunities with readings of 38 degrees F and 30 degrees F, respectively. In addition, the (licensee name) Refrigerator/Freezer Temp Log indicated if the refrigerator temp (temperature) is below between 32-40 degree [sic], please contact Culinary Manager or Maintenance [sic]. On October 22, 2024, at 10:17 a.m., unlicensed personnel (ULP)-G stated ULP-G thought the medication refrigerator temperature was supposed to be check daily, however, ULP-G stated ULP-G was not sure which shift checked the temperature of the medication refrigerator. On October 22, 2024, at 2:23 p.m., RN-C stated the refrigerator temperature logs were to be documented on daily, however, RN-C was not sure what staff was assigned to check the medication refrigerator temperature. CNS-B stated the night staff should have been assigned to check the medication refrigerator temperature and an acceptable medication refrigerator temperature would be around 40 degrees F. Director of operations (DO)-K further stated staff may have checked the medication refrigerator temperature, when staff had to open the medication refrigerator to get a medication for administration. The manufacturer's instructions for Lorazepam Oral Concentrate dated August 2022, indicated to store lorazepam in the refrigerator at 36 degrees	01880		

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01880	Continued From page 32 F to 46 degrees F. The licensee's Storage of Medications policy dated August 1, 2021, indicated medications will be handled and stored per acceptable standards of clinical practice. In addition, the RN will provide education to the resident/resident's representative on proper storage of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to the manufacturer's recommendations. This may include a combination of the resident's room, medication cart and the nursing office. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940		

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01940	Continued From page 33 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R10) who had treatments or therapies managed by the licensee. 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: During the entrance conference on October 21, 2024, at 10:15 a.m., registered nurse (RN)-C stated the licensee provided treatment management services, including blood glucose checks (treatment to check level of sugar in the	01940		

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01940	Continued From page 34 blood), to residents at the facility. R10's diagnoses included chronic obstructive pulmonary disease (COPD- difficult to breathe), diabetes, and hypertension (HTN-high blood pressure). R10's prescriber orders dated September 26, 2024, included an order to check blood sugar daily in the morning. R10's Assessment dated September 12, 2024, indicated R10 received blood glucose checks daily. On October 22, 2024, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-G complete a scheduled blood glucose check for R10. Immediately following the observation, ULP-G returned to document in R10's electronic medical record and ULP-G stated R10's medical record did not list parameters to notify an RN if R10 had a high or low blood sugar level, however, ULPs just knew to check R10's blood glucose every morning. R10's service plan dated July 1, 2024, lacked a written statement of the treatment of services the resident received to include a blood glucose check daily. R10's record lacked evidence of an individualized treatment or therapy management plan which included the following: -identification of treatment or therapy tasks that will be delegated to ULPs; and -procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments or therapy services.	01940		

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01940	Continued From page 35 On October 23, 2024, at 1:37 p.m., RN-C stated R10's blood glucose checks do not have parameters for ULPs to refer to in the licensee's electronic medical record system, however, ULPs were trained upon hire to know parameters of high and low blood glucose levels. The licensee's 7.05 Treatment and Therapy Management Plan policy dated August 2021, indicated the treatment and therapy management plan would include the following: - identification of treatment or therapy tasks that will be delegated to ULP: and -procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24	02070		

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VISTA PRAIRIE AT WINDMILL PONDS MEMOR'	803 VICTOR STREET ALEXANDRIA, MN 56308

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02070	Continued From page 36 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in two of two secured dementia care units. This had the potential to affect all residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order on October 22, 2024. The findings include: The licensee failed to ensure one or more staff were always available during all shifts in each of the two separate secured dementia care units. The licensee held an Assisted Living with Dementia Care license with a capacity of 26 residents and had a current census of 16 residents. On October 21, 2024, the surveyor observed two main entrances with separate addresses labeled on the outside of the entrances (803 and 803 ½). During the entrance conference on October 21, 2024, at 10:21 a.m., registered nurse (RN)-C stated the facility's staffing schedule included three to four unlicensed personnel (ULPs) on the day shift (6:00 a.m. to 2:00 p.m.), two ULPs on duty on the evening shift (2:00 p.m. to 10:00	02070		

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	26046	A. BUILDING: _____ B. WING _____	10/23/2024

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VISTA PRAIRIE AT WINDMILL PONDS MEMOR'	803 VICTOR STREET ALEXANDRIA, MN 56308

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02070	Continued From page 37 p.m.), one ULP for a short shift (4:00 p.m. to 9:00 p.m.), and two ULPs on duty on the night shift (10:00 p.m. to 6:00 a.m.). Monday through Friday clinical nurse supervisor (CNS)- B and RN-C worked approximately 8:00 a.m. until 5:00 p.m. At 10:22 a.m., CNS-B stated two residents used two-person mechanical lifts in the facility. The physical layout of the facility consisted of two units (Lake Henry and Lake Agnes) connected by a link (large community room). On October 21, 2024, at 3:12 p.m., director of maintenance (DM)-D measured each unit consisting of a hallway, which measured 140 feet in length. DM-D measured the link at 75 feet in length and was separated by fire exit doors, which required a key code to open. DM-D stated the fire doors were rated for 20 minutes and were held open by a quick-release door stoppers that DM-D had installed. DM-D further stated the door stoppers would not shut without a staff member manually pushing on the quick release of the door. DM-D further stated the link doors are open during the day and the link doors are closed at night. The Lake Henry unit had seven residents with one resident that required a two-person mechanical lift transfer. The Lake Agnes unit had nine residents with one resident that required a two-person mechanical lift transfer. The facility's Uniform Disclosure of Services (UDALSA) dated July 1, 2024, indicated the number of direct care staff typically scheduled per shift at maximum resident capacity was three ULPs on the day shift; three ULPs on the evening shift; and two ULPs on the night shift. The facility's Direct-Care Staffing Plan dated June 28, 2024, based on number of residents indicated the night shift (10:00 p.m. to 6:00 a.m.) should be	02070		

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02070	Continued From page 38 covered with one ULP at the "Care Suites" (Lake Henry and Lake Agnes units), and one ULP at the assisted living (building across the street owned by the same company). In addition, when residents require a two-person assist there will be a minimum of two staff available at all ties and there will be 24-hour, awake staff available to respond to resident requests for assistance with health and safety needs. The licensee's Master Schedule dated August 26, 2024, until November 3, 2024, indicated one ULP was scheduled to work each night (10:00 p.m. until 6:00 a.m.) on each unit of Lake Agnes and Lake Henry. On September 12, 2024, at 10:09 p.m., R2 had a fall and required the assistance of two ULPs to be transferred up off the floor. On October 2, 2024, at 5:15 a.m., R3 had a fall and required the assistance of two ULPs to bet R3 back into bed. On October 21, 2024, at 1:43 p.m., the surveyor observed ULP-F and ULP-G assist R5 transfer from the Broda chair to the bed with the use of a mechanical lift. During the observation, ULP-F and ULP-G stated two staff are required when transferring residents with a mechanical lift. On October 21, 2024, from 11:07 a.m. until 3:45 p.m., the surveyor observed both Lake Henry and Lake Agnes doors at the link were held open with the quick release door stops. On October 22, 2024, from 5:34 a.m. until 11:12 a.m., the surveyor observed the Lake Henry door connected to link was shut, locked, and required a keypad to open the door to enter the Lake	02070		

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02070	Continued From page 39 Henry unit. On October 22, 2024, from 5:34 a.m. until 7:22 a.m., the surveyor observed the door from Lake Agnes to the link was propped open with the quick release door stop. From 7:23 a.m. until 11:12 a.m., the surveyor observed the Lake Agnes door connected to the link to be closed, locked, and required a keypad to enter the link. On October 22, 2024, at 5:28 a.m., the surveyor entered the Lake Henry door of the facility where ULP-H and ULP-I were present in the Lake Henry kitchen area. ULP-I stated I (ULP-I) better get back to my unit (Lake Agnes) and walked back towards the link where the door was shut to the link and required a keypad to open the door. On October 22, 2024, at 5:30 a.m., ULP-H stated the door between the link and each unit are typically locked and shut due to residents that wander. ULP-H stated ULP-H has left the locked unit to go assist a ULP on the other side or if a two-person transfer is required with a mechanical lift. On October 22, 2024, at 5:35 a.m., ULP-I stated all staff is helpful at night and if assistance is needed on another unit, ULP-I would go assist the other ULP, however, would carry the beeper and walkie talkie with, so residents on ULP-I's unit would still be able to call ULP-I for assistance. On October 22, 2024, at 5:48 a.m. until 5:50 a.m., the surveyor observed ULP-I take out the trash on the Lake Agnes unit with no other staff present on the unit and the door from the link to Lake Henry was shut, locked, and required a keypad to open. On October 22, 2024, at 6:10 a.m., RN-C stated	02070		

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02070	Continued From page 40 sometimes the doors from the link to each unit are closed due to resident behaviors. CNS-B further stated CNS-B had instructed staff to keep both doors to the link propped open all the time. RN-C further stated the building should not be left unoccupied at any time. On October 22, 2024, at 6:29 a.m., RN-C stated RN-C could not say for sure if the locked keypad doors from the link to each unit were fire rated or if the doors would close automatically if a fire was to occur and that would be a question to address with the maintenance department. The licensee's undated Transfer a Resident: Sling (Hoyer) Lift Use indicated always use two (2) staff to transfer with lifts. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 5., indicated a minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee provided actions to mitigate the immediacy of correction order 2070 to surveyor supervisor on October 22, 2024, at 2:24 p.m., however, non-compliance remains at a scope and level of three, widespread (I).	02070		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 41 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R6) with a consumer bed rail. 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 October 21, 2024, at 10:02 a.m., registered nurse (RN)-C stated the licensee was familiar with current minimum assisted living requirements. R6's diagnoses included Alzheimer's disease. R6's Service Plan dated July 1, 2024, indicated R6 required assistance with medication administration, oxygen management, bathing, grooming, dressing, toileting, and housekeeping. R6's Bed Rail Assessment dated July 10, 2024,	02310		

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02310	Continued From page 42 indicated R6 had a consumer ¼ bed rail on the left and right side of R6's bed and R6 was assessed for the use of consumer bed rails. The consumer bed rails were installed per family preference and to provide a sense of security while R6 was in bed. The consumer bed rails precautions and alternatives to bed rails were discussed with R6's spouse, and the Consumer Product Safety [sic] (Safety) Commission (CPSC) website was checked for recalls. R6's 90-day Assessment dated September 19, 2024, indicated R6 had a consumer ¼ bed rail on the left and right side of R6's bed listed under bed mobility. R6's record lacked evidence the licensee completed a physical inspection of the bed rails, bed rails were maintained according to manufacturer's guidelines, and referred to the CSPC website for bedrail recall information at least every 90 days with the requirement included in the uniform assessment tool for assessing assistive devices. On October 23, 2024, at 1:05 p.m., RN-C stated the RN checks a resident's consumer bedrail each year with assessment. RN-C further stated RN-C was not aware of all required content for a bed rail assessment to be conducted at least every 90 days. The licensee's Subject: Assessing the Safety of Side Rails (bed rails) policy dated July 23, 2022, indicated continued use of physical devices will be assessed at least every 90 days or with a significant change to determine if the device is still needed to enhance the resident's safety and/or bed mobility. Physical devices will be reviewed for safety and used according to	02310		

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02310	Continued From page 43 manufacturer's recommendations. In addition, physical devices will be assessed for safety during each re-assessment and the Director of Health Services or designee, will check the CPSC website for recalls on bed assistive devices. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 15, 2024, "Documentation about a resident's consumer bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; -Installation and sue according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements."	02310		

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02310	Continued From page 44 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) 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 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	02410		

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02410	Continued From page 45 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 seven residents (R5) while receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on October 21, 2024, at 10:02 a.m., registered nurse (RN)-C stated the licensee was familiar with current minimum assisted living requirements.	02410		

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02410	Continued From page 46 R5's record indicated R5 received the Minnesota Bill of Rights for Assisted Living Residents dated July 1, 2024. On October 21, 2024, at 1:43 p.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-G transfer R5 from the Broda chair to the bed with the use of a mechanical lift in R5's room. R5's bed was located against the wall with one window adjacent to R5's bed that faced the resident and visitor patio area, and another window located straight across the room from R5's bed that faced the parking lot and sidewalk used for any residents, staff, or visitors. ULP-F and ULP-G proceeded to undress R5's lower body by rolling R5 side to side, changed R5's brief, provided peri care, and redressed R5's lower body with a brief and pants. Throughout the observation R5's window shades remained open, which would have allowed any resident, visitor, or staff walking by R5's windows to view inside. On October 22, 2024, at 10:16 a.m., ULP-G stated ULPs typically shut R5's shades when providing toileting services in R5's room. On October 22, 2024, at 2:19 p.m., director of operations (DO)-K stated the expectation for resident privacy, when ULPs were providing personal care, included making sure the resident door was shut. On October 22, 2024, at 2:20 p.m., RN-C stated it would depend on the location of a resident bed and where staff were standing when providing personal care if a resident window shade would need to be shut or not. RN-C further stated it would be best practice to close the window shade, however, if the resident and staff are away from a resident window then there would not be a	02410		

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02410	Continued From page 47 privacy issue. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated June 2022 indicated in section Applicability: 10. Personal and treatment privacy: Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. 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: *10/21/24*
Time: 15:35:19
Report: 7935241092

Food and Beverage Establishment Inspection Report

Location:
Vista Prairie at Windmill PMC
803 Victor Street
Alexandria, MN56308
Douglas County, 21

Establishment Info:
ID #: 0037715
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207621448
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.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CLEAN UNDER CABINETS IN THE KITCHEN.

Comply By: 10/24/24

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: Dish Machine 1
Violation Issued: No

Hot Water: = at 170 Degrees Fahrenheit
Location: Dish Machine 2
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Cooler
Violation Issued: No

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

Type: Full
Date: *10/21/24*
Time: 15:35:19
Report: 7935241092
Vista Prairie at Windmill PMC

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 7935241092 of 10/21/24.

Certified Food Protection Manager: Judy Mattocks

Certification Number: 26669 Expires: 10/19/26

Signed: _____
Establishment Representative

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