Electronically Delivered

May 2, 2023

Licensee
Vista Praire Monarch Meadows
2135 Lor Ray Drive
North Mankato, MN 56003

RE: Project Number(s) SL30703015

Dear Licensee:

On April 20, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 21, 2022. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 21, 2022 survey.

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

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

IMPOSITION OF FINES:

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.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is

substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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 *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL30703015 On April 18, 2023, through April 20, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 20, 2023. At the time of the survey, there were 84 residents: 84 receiving services under the Assisted Living Facility license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 480}	Continued From page 1 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: No Further Action Required	{0 480}		
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 730}	Continued From page 2 professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of eight resident records (R26) included documentation of services provided and of reporting a change to the registered nurse as directed per the service plan. 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: R26's diagnoses included congestive heart failure	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 730}	Continued From page 3 and hypertension (high blood pressure). R26's Service Plan Agreement dated April 4, 2023, included a service that directed staff to weigh R26 before breakfast and verbally report a weight change of three pounds (up or down) to the nurse. The nurse will evaluate weight changes and will communicate with the primary care provider as indicted. R26's Service Checkoff List dated April 2023, included the service to weigh the resident every day before breakfast and verbally report weight changes of three pounds (up or down) to the nurse. A review of the documentation revealed four days (April 10, 13, 14, and 17, 2023) where there were no weights recorded. The documentation further indicated on April 14, 2023, R26's weight was 224 pounds; on April 15, 2023, R26's weight was 227 pounds (a three pound increase). R26's record did not include evidence of staff notification to the nurse. On April 19, 2023, at 2:30 p.m. licensed assisted living director (LALD)-N confirmed there was no evidence in R26's record to indicate if the on call nurse had been notified of the weight gain on April 16, 2023. The licensee's Resident Record Documentation policy dated August 2021, indicated staff providing assisted living services "will document, daily, medications, services, treatments, or therapies provided to residents." No further information provided.	{0 730}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 810}	Continued From page 4 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No Further Action Required	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01530}	Continued From page 5	{01530}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of eight employees (unlicensed personnel (ULP)-M) received the required dementia care training. 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	{01530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01530}	Continued From page 6 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: ULP-M had a hire date of September 20, 2022. ULP-M's record included five hours of training for dementia topics, but lacked an additional three hours of training to meet the required eight hours within 160 working hours of employment start date. On April 20, 2023, at 8:30 a.m. licensed assisted living director (LALD)-N confirmed ULP-M, who had been cited on the previous survey, still had not completed the required hours of dementia training. The licensee's Dementia Training policy dated August 2021, indicated direct care employees would complete eight hours of initial training within 160 hours of the employment start date. No further information was provided.	{01530}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 7	{01620}		

from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment, for one of three residents (R24).

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:

R24's record lacked evidence the RN conducted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 8 a reassessment no more than 90 calendar days from the date of the last assessment. R24's diagnoses included congestive heart failure and type II diabetes. R24's Service Plan Agreement dated February 7, 2023, included bathing, dressing, toileting, blood sugar checks, meals, laundry, and housekeeping. R24's last two assessments dated January 9, 2023, and April 14, 2023, were provided. 95 days had passed between assessments (five days late). On April 20, 2023, at 9:55 a.m. organizational director of health care (ODHC)-B confirmed R24's last quarterly assessment was conducted after the 90 day requirement. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Assisted Living License policy dated August 1, 2021, indicated a RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. No further information was provided.	{01620}		

Electronically Delivered

February 10, 2023

Licensee
Vista Prairie at Monarch Meadows
2135 Lor Ray Drive
North Mankato, MN 56003

RE: Project Number(s) SL30703015

Dear Licensee:

On January 20, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 21, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the October 21, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 21, 2022, found not corrected at the time of the January 20, 2023, follow-up evaluation and/or subject to penalty assessment are as follows:

0250-Conditions-144g.20 Subdivision 1- $500.00
0510-Infection Control Program-144g.41 Subd. 3 - $500.00
0620-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 (a)
0660-Tuberculosis Prevention And Control-144g.42 Subd. 9 - $500.00
0730-Contents Of Resident Record-144g.43 Subd. 3 - $500.00
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4
1530-Training In Dementia Care Required-144g.64 - $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $3,000.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f)
1700-Provision Of Medication Management Services-144g.71 Subd. 2
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1950-Administration Of Treatments And Therapy-144g.72 Subd. 4
1970-Treatment And Therapy Orders-144g.72 Subd. 6
3000-Timing Of Report-626.557 Subd. 3

The details of the violations noted at the time of this follow-up evaluation completed on January 20, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up evaluation completed on January 20, 2023, we identified the following violation(s):

1690-Medication Management Services-144g.71 Subdivision 1

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $5,500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

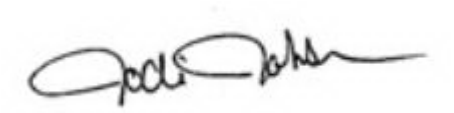
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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 *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL30703015 On January 17, 2023, through January 20, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 21, 2022. At the time of the survey, there were 76 residents; all of whom were receiving services under the provider's Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 250}	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner;	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 250}	Continued From page 2 (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During prior survey exited on October 21, 2022, during the entrance conference on October 17, 2022, at 11:31 a.m. registered nurse/organizational director of Health Care (RN/ODOHC)-B stated the licensee's employees	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 250}	Continued From page 3 in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 250}	Continued From page 4	{0 250}		

conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective
process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 250}	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent on May 9, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 23, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals;	{0 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 250}	Continued From page 6 As a result of this survey, the following orders were reissued/or issued 0510, 0620, 0660, 1440, 1530, 1620, 1690, 1700, 1730, 1760, 1940, 1950, 1970 and 3000 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	{0 250}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 510}	Continued From page 7 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19; failed to ensure one of four unlicensed personnel (ULP-P) washed hands when observed providing resident care services and failed to ensure catheter bag was cleansed for one of two residents (R13) observed for catheter cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: EMPLOYEE FACIAL MASKS	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 510}	Continued From page 8 On January 17, 2023, at 9:10 a.m. upon entrance to the facility multiple staff persons were noted not to be wearing facial masks. On January 17, 2023, at 10:39 a.m. during the entrance conference, licensed assisted living director (LALD)-N stated two employees were not working due to testing positive for COVID-19. LALD-A stated no residents had tested positive for COVID-19. LALD-N verified staff were not wearing masks and stated, "No masks" needed to be worn by staff "unless they feel they want too". The Minnesota Department of Health (MDH) COVID-19 Source Control (Masking), PPE (personal protective equipment), and Testing Grid dated November 2, 2022, indicated for staff PPE "when community transmission levels are high: source control recommended"; facility should consider universal use or eye protection; facility should consider broad use or respirators (personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles). Source control options for health care workers included a well-fitting facemask. The Centers for Disease Control and Prevention (CDC) COVID Data Tracker on January 17, 2023, indicated Nicollet County, Minnesota (the county of the assisted living facility) was at a "high" level of community transmission. On January 17, 2023, at 1:15 p.m. when queried if staff should be wearing facial masks, LALD-N stated, "I am having someone look into that right now". LALD-N stated, "We should be masking if high," referring to the community transmission	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 510}	Continued From page 9 level. The licensee's Guidance Reference updated December 7, 2022, indicated "masks must be worn when community transmission rates are high". HAND WASHING/CATHETER BAG CLEANED R13's diagnoses included multiple sclerosis (a potentially disabling disease of the brain and spinal cord causing communication problems between your brain and the rest of your body) and neurogenic bladder (a bladder malfunction caused by an injury or disorder of the brain, spinal cord, or nerves). R13's Service Plan Agreement effective July 29, 2022, indicated the resident received catheter care. On January 18, 2023, at 8:55 a.m. ULP-P was observed changing R13's large urinary catheter drainage bag to a new leg drainage bag. ULP-P cleansed hands prior to entering the resident's room. Upon entering the room, ULP-P donned gloves and informed R13 she would be changing his catheter bag. ULP-P removed the urinary bag tubing attachment from the catheter while the resident pinched the catheter off to avoid any urine flow. ULP-P then cleansed the end of the catheter with an alcohol pad prior to inserting the tubing attachment from the new catheter leg bag. ULP-P then told R13 she would empty his large urinary bag which was stored in a plastic container on the floor below his bed. ULP-P took the urinary bag and container into the bathroom and emptied the urine from the catheter bag into the toilet, placed the bag back into the plastic container and placed it onto the floor in the	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 510}	Continued From page 10 bathroom. ULP-P then doffed her gloves and returned to R13's bedside without cleansing her hands. ULP-P asked the resident how old his large urinary catheter bag was and he said it wasn't that old. ULP-P attached the leg straps to the catheter bag and asked R13 if he needed anything else, then exited the apartment without cleaning out the large urinary drainage bag or cleansing her hands. ULP-P walked down the hall with the surveyor and did not utilize any of the hand sanitizer stations on the way, and headed back to the medication cart down the hall. At 9:05 a.m., the surveyor asked ULP-P when she would wash her hands. ULP-P stated after she had emptied the large catheter bag of urine. ULP-P confirmed she had not washed her hands after emptying the catheter bag and removing her gloves, and further confirmed she had not cleansed her hands since before entering R13's room. On January 20, 2023 at 1:23 p.m. interim director of health services (IDHS)-S confirmed with catheter care hands should be cleansed upon removal of gloves, and the catheter bag should be cleaned after emptying when changing to a different bag. The licensee's Hand Hygiene policy dated July 19, 2021, indicated hand washing "shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace handwashing." Hands should be washed or decontaminated: a. Before and after direct contact with a resident; b. If moving from a contaminated body site to a clean body site during care; d. after removing gloves or gowns.	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 510}	Continued From page 11 No further information was provided.	{0 510}		
{0 620} SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (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. 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) suspected maltreatment for one of one resident (R12). 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: R12's diagnoses included bipolar disorder. R12's unsigned Service Plan Agreement effective July 21, 2022, indicated the resident received	{0 620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 620}	Continued From page 12 services including medication administration, blood glucose checks, meals, and housekeeping. The MAARC report submitted January 9, 2023, at 14:14 (2:14 p.m.), indicated on January 7, 2023, at 3:10 p.m. a resident assistant (RA) reported that registered nurse (RN)-Q, was verbally aggressive and made threatening statements towards a resident under her care. The encounter took place in a community area of the building and was witnessed by staff and other residents. The incident caused the resident to breakdown into tears and was emotionally distraught. The RA reporting the incident followed the resident (R12) back to her room where he proceeded to provide care and emotional support for a half hour. The nurse (RN-Q) has been put on suspension pending further investigation. The MAARC report was submitted 49 hours after the alleged allegation. On January 17, 2023, at 1:20 a.m. licensed assistant living director (LALD)-N confirmed the MAARC Report for R12 was reported greater than 24 hours after occurrence. LALD-N stated the incident was reported by an unlicensed personnel (ULP) to an interim RN who then made the report to LALD-N, greater than 24 hours after it occurred. LALD-N further stated the alleged perpetrator, RN-Q, was the nurse working at the time of the incident and should have self-reported. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult would report the incident immediately to their "LALD" (licensed assisted living director), director of health services or designee and that person would complete an	{0 620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 620}	Continued From page 13 incident report. If the incident appears to be suspected abuse, neglect or financial exploitation, the LALD, director of health services or designee would immediately report to the "CEP" (common entry point). No further information was provided.	{0 620}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff, and visitors.	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 660}	Continued From page 14 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: The licensee's TB facility risk assessment dated December 18, 2020, indicated the licensee was a low risk. Unlicensed personnel (ULP)-G had a hire date of September 20, 2022, and provided direct care and services to the licensee's residents. ULP-H had a hire date of August 17, 2021, and provided direct care and services to the licensee's residents. ULP-I had a hire date of December 28, 2021, and provided direct care and services to the licensee's residents. ULP-J had a hire date of November 1, 2000, and provided direct care and services to the licensee's residents. ULP-L had a hire date of October 4, 2022, and provided direct care and services to the licensee's residents. ULP-M had a hire date of September 20, 2022, and provided direct care and services to the licensee's residents. ULP-G, ULP-H, ULP-I, ULP-J, ULP-L and ULP-M's records lacked documented evidence of training for the licensee's TB infection control plan.	{0 660}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 660}	Continued From page 15 On January 18, 2023, at 2:14 p.m. ULP-D stated, "No, we did not do TB plan training yet with staff". On January 20, 2023, at 11:27 a.m. licensed assisted living director (LALD)-N stated, "I'll verify if added [TB plan] into VP [vista prairie] educare. VP creates own educare topics and if they [staff] were trained. I'll look into that". No further information was provided. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated TB training is required at time of hire for all health care workers and the content should focus on basic information: Your health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. The licensee's Tuberculosis Screening policy dated October 2022, indicated staff would be educated regarding TB at the time of hire. Content of training would focus on basic information which included the licensee's infection control plan (i.e. how to implement your early recognition, isolation, and referral procedure, especially any sections that the employees are responsible for implementing. No further information was provided.	{0 660}		
{0 730} SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 730}	Continued From page 16 name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation,	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 730}	Continued From page 17 when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required for three of five residents (R3, R11, R10). 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: R3 R3's record lacked documented information for emergency contact and medical service providers. R3's Face Sheet printed January 17, 2023, included responsible party name and phone number, but lacked the address for the person listed; included name and phone number for the pharmacy, but lacked the address of the pharmacy; and included the name of hospital preference and transportation, but lacked the address and telephone number for the hospital and transportation preferences listed.	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 730}	Continued From page 18 R11 R11's record lacked documented information for emergency contact, designated representative and medical service providers and lacked documentation for services being provided. R11's Face Sheet printed January 18, 2023, included emergency contact and case manager names and phone numbers, but lacked the address for the persons listed; included name and phone number of physician, but lacked the address of the physician; included name and phone number for the pharmacy, but lacked the address of the pharmacy; included names for pulmonary and ear, nose , throat persons, but lacked the address and phone numbers pf the persons listed; and included the name of hospital preference, but lacked the address and telephone number for the hospital preference listed. R11's Service Checkoff List dated January 2023, lacked consistent documentation services were provided for the following: -appointment reminder at 5 a.m. on Tuesday, Thursday, Saturday -garbage removal a.m. -laundry a.m. on Thursday -meal noon verify attendance -daily check at 2 p.m. -garbage removal p.m. -meal supper verify attendance -pendent check 7 p.m. Wednesday -garbage removal nights -meal breakfast verify attendance On January 20, 2023, at 11:27 a.m. licensed assisted living director (LALD)-N reviewed R11's Service Checkoff List. LALD-N verified the sheet lacked documentation for services being provided	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 730}	Continued From page 19 and stated "if [R11] refuses the service, should show initials" of staff. LALD-N verified R3's and R11's Face sheets lacked the above information. R10 R10's diagnoses included diabetes and urge incontinence. R10's Service Plan Agreement effective August 19, 2021, indicated R10 received services including bathing, medication administration, toileting plan, blood sugar checks, meals, laundry, and housekeeping. On January 17, 2023, at 11:54 a.m. ULP-P was observed to provide a blood sugar check for R10. R10's Medication Administration Record (MAR) dated January 2023, indicated the ULP would provide blood sugar checks twice daily and PRN (as needed) and to notify nursing staff when R10's blood sugar was below 70 and above 300. The order also indicated to inform the nurse if blood sugar below 90 or above 350. The MAR indicated the blood sugar readings were out-of-range for the following dates and times: January 12, 2023, at approximately 9:00 a.m. (300); January 12, 2023, at approximately 12:00 p.m. (359); January 12, 2023, at approximately 4:00 p.m. (315); January 12, 2023, at approximately 8:00 p.m. (434); January 13, 2023, at approximately 8:00 p.m. (342); January 118, 2023, at approximately 9:00 a.m. (87) and; January 19, 2023, at approximately 9:00 a.m.	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 730}	Continued From page 20 (84). R10's record lacked documentation the ULP notified a nurse regarding out of range blood sugars, and the record lacked follow up documentation by the nurse. On January 20, 2023, at 1:23 p.m. interim director of health service (IDHS)-S confirmed R10's record did not include documentation of notifying a nurse when blood sugar parameters were out of range. R10's Service Checkoff List dated January 2023, lacked documentation of receiving services to include the following: Toileting plan at 3:00 a.m. - January 1, 2, 3, 4, 5, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18; Toileting plan PM - January 1, 2, 3, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18. On January 20, 2023, at 12:00 p.m. LALD-N confirmed R10's toileting plan was not consistently documented on the Service Checkoff List. The licensee's Resident Record Information and Content policy dated August 2021, indicated the resident record "must include" the name, addresses, and telephone numbers of the resident's emergency contact, legal representatives, designated representative and the resident's health and medical service providers, if known. The licensee's Resident Record Documentation policy dated August 2021, indicated staff providing assisted living services "will document, daily, medications, services, treatments, or therapies provided to residents."	{0 730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 730}	Continued From page 21 No further information provided.	{0 730}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{0 810}	Continued From page 22 This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{01440} SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the facility for three of six unlicensed personnel (ULP-I, ULP-M,	{01440}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01440}	Continued From page 23 ULP-L). 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: ULP-I, ULP-M and ULP-L's records lacked documented evidence of a registered nurse (RN) supervising ULP-I, ULP-M and ULP-L performing delegated tasks. ULP-I had a hire date of December 28, 2021. ULP-I's record included two 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks dated December 28, 2022, which indicated ULP-I was competent for multiple delegated tasks. ULP-M had a hire date of September 20, 2022. ULP-M's record included a 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks dated December 6, 2022, which indicated ULP-M was competent for multiple delegated tasks. ULP-L had a hire date of October 4, 2022. ULP-L's record included a 30 Day and/or Periodic Supervision of Staff Providing Delegated	{01440}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01440}	Continued From page 24 Medication Tasks dated December 8, 2022, which indicated ULP-L was competent for multiple delegated tasks. On January 18, 2023, at 2:14 p.m. ULP-D stated ULP-I, ULP-M, and ULP-L's 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks as noted above, was the RN documented competency for medication and treatment administration tasks, and was not a 30-day supervision task. Licensed assisted living director (LALD)-N verified 30 day supervision of delegated tasks by the RN was to be completed within 30 days after the date training and competency of delegated tasks. ULP-D verified ULP-I, ULP-M and ULP-L's records lacked direct supervision by the RN of staff performing delegated tasks within 30 calendar days as required. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated supervision of ULP by an RN would be direct supervision of the staff performing the delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks. No further information was provided.	{01440}		
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working	{01530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01530}	Continued From page 25 hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure five of five employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I, ULP-M, ULP-L) received the required dementia care training. 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:	{01530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01530}	Continued From page 26 ULP-G ULP-G had a hire date of September 20, 2022, and provided direct care and services to the licensee's residents. On January 18, 2023, at 8:08 a.m. ULP-G was observed to administer medications to R8. ULP-G's record included seven hours of training for dementia topics, but lacked an additional one hour of training to meet the required eight hours within 160 working hours of employment start date and lacked documented evidence of training for the required topic of person-centered planning and service delivery. ULP-H ULP-H had a hire date of August 17, 2021, and provided direct care and services to the licensee's residents. ULP-H's record lacked documented evidence of training for the required topic of person-centered planning and service delivery. ULP-I ULP-I had a hire date of December 28, 2021, and provided direct care and services to the licensee's residents. ULP-I's record included five hours of training for dementia topics, but lacked an additional three hours of training to meet the required eight hours within 160 working hours of employment start date and lacked documented evidence of training for the required topic of person-centered planning and service delivery. ULP-M had a hire date of September 20, 2022.	{01530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01530}	Continued From page 27 ULP-M's record included five hours of training for dementia topics, but lacked an additional three hours of training to meet the required eight hours within 160 working hours of employment start date and lacked documented evidence of training for the required topic of person-centered planning and service delivery. ULP-L had a hire date of October 4, 2022. ULP-L's record lacked documented evidence of training for the required topic of person-centered planning and service delivery. On January 18, 2023, at 2:14 p.m. ULP-D verified ULP-G, ULP-H, ULP-I, ULP-M and ULP-L's records lacked the above for dementia training. ULP-D stated, "We must not have added person-centered planning and service topic" to the licensee's system for training. The licensee's Dementia Training policy dated August 2021, indicated direct care employees would complete eight hours of initial training within 160 hours of the employment start date and the training would include the required topics per 144G.64 subd. (5). No further information was provided.	{01530}		
{01620} SS=H	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 28	{01620}		

resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment for change in condition for four of five residents (R11, R18, R20, R21); failed to ensure comprehensive assessment to include required areas of assessment for three of three residents (R11, R3, R7) and failed to ensure the RN completed comprehensive reassessment and monitoring every 90 days as required for one of five residents (R10).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 29 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: R11 R11's diagnoses included chronic kidney disease stage 4 (severe) (dialysis recipient) and Parkinson's disease. R11's Service Plan Agreement dated August 3, 2022, included meals, COVID-19 monitoring, pendant check, vital signs, appointment reminder, garbage removal, housekeeping, laundry, medication administration and daily check. ASSESSMENT OF PRESSURE ULCER WOUND R11's record lacked documented evidence of comprehensive nursing assessments by the RN for pressure ulcer wound (size, appearance, odor, drainage, pain). R11's Clinic note dated December 6, 2022, indicate wound care "9/14" (September 14, 2022), right sacral ulcer stage 2, left Ischial is now healed. R11's Physician Order Sheet dated January 3, 2023, included the following: -routine treatments; start date May 5, 2022, bordered foam dressing change foam dressing two times per week and as needed (PRN) when soiled -start date May 27, 2022, mupirocin 2% topical ointment (bactroban 2% topical ointment) (antibiotic) apply small amount to bilateral buttock	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 30 ulcers with dressing changes. Changing dressing three times a week. R11's Progress Note identified the following: -January 9, 2023, documented by service support coordinator (SSC)-U, indicated wound care late entry for January 3, 2023. Resident seen wound care department at clinic. Right sacral ulcer stage 2, small open area. No signs of infection. Continue bordered foam "MWF" (Monday, Wednesday, Friday) until closed. Instructed to apply barrier cream to surrounding skin. Left Ischial is now healed. Ischial pressure ulcers are also healed, but tender, dry scaling skin noted. Will ask her to apply barrier cream daily for comfort and skin protection. Will need off loading consistently. R11's Medication Administration Record dated January 2023, included the following: -border foam dressing change foam border dressing two times per week and as needed (PRN) when soiled -mupirocin 2% topical ointment (bactroban 2% topical ointment) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. On January 18, 2023, at 10:53 a.m. unlicensed personnel (ULP)-J stated R11's Medication Administration Record (MAR) included wound dressing change to be done by the ULP. ULP-J stated R11 "tells [staff] when needs changing" for the wound dressing. ULP-J stated when she changed the dressing on R11's buttock she applied mupirocin ointment to the wound and covered the area with Mepilex dressing. ULP-J stated a homecare agency was also changing the dressing.	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 31 On January 18, 2023, at 11:05 a.m. observation of R11's buttocks identified a foam dressing was in place on R11's left buttock. Removal of the dressing by a homecare agency RN revealed an open area on R11's left buttock. R11's right buttock skin was intact and had no open areas. Homecare agency RN was observed to remove old dressing form R11's left buttock, apply Triad cream (coloplast hydrophilic wound dressing paste that keeps wound covered and protected from incontinence) to the open area and covered the open area with a Mepilex foam dressing. R11's 90 Day Assessment dated November 21, 2022, indicated "skin integrity open areas describe:". The assessment lacked documented information of open areas. R11's Change in Condition Assessment dated January 2, 2023, indicated "skin integrity open areas describe:". The assessment lacked documented information of open areas. R11's record lacked documented evidence of comprehensive assessment of pressure ulcers/wounds upon development and with changes in skin for pressure area wounds, including consistent weekly assessment of pressure ulcer wounds to include size, appearance, odor, drainage and pain. On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S stated she had not looked at R11's buttocks or assessed R11's pressure wound. IDHS-S stated homecare agency started providing wound dressing treatments for R11 on January 3, 2023. LALD-N and IDHS-S reviewed R11's record and verified there was no documented evidence of comprehensive assessment of pressure	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 32 ulcers/wounds upon development and with changes in skin for pressure area wounds, including consistent weekly assessment of pressure ulcer wounds to include size, appearance, odor, drainage and pain. LALD-N stated the licensee "did look" for documentation from the homecare agency for R11's wounds, "we didn't find it." CHANGE IN CONDITION RIGHT LOWER LEG R11's record lacked documented evidence of comprehensive nursing assessment by the RN for change in condition related to right lower leg open area and cellulitis. R11's record identified the following: -Progress Note dated December 28, 2022, documented by IDHS-S, resident has open area to right lower leg that she scratched raw due to itching. Open area is approximately two inches around with small scratch marks around area. Cleaned off with water and patted dry. Applied bandage. Applied Aquafor to bilateral legs with some itch relief. -After Visit Summary hospital dated December 30, 2022, through January 2, 2023, indicated admitting diagnosis: chronic obstructive pulmonary disease exacerbation. Your diagnoses also included: cellulitis. Start taking cefdinir (antibiotic used to treat cellulitis), doxycycline monohydrate (antibiotic) and prednisone (helps reduce inflammation). -Progress Note dated January 7, 2023, documented by IDHS-S, indicated late entry for January 2, 2023, original entry must have been deleted by accident. Resident back approximately 6:00 p.m. in the evening after dialysis. Diagnosis of cellulitis to right lower leg. Homecare will start January 3, 2023, for wound care to right lower leg.	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 33 R11's Change in Condition Assessment dated January 2, 2023, indicated "skin integrity open areas describe:". The assessment lacked documented information of open areas. R11's record lacked documented evidence of monitoring of open area right lower leg from onset of December 28, 2022, and after development of cellulitis to right lower leg upon return form hospital on January 2, 2023. On January 20, 2023, at 11:27 a.m. IDHS-S stated regarding documentation of R11's right lower leg open area, "nothing happened after that note", referring to R11's progress note dated December 28, 2022. IDHS-S stated, "Yes" R11 was hospitalized and was diagnosed with cellulitis right lower leg. IDHS-S stated she had looked at R11's right lower leg since returning from the hospital and there was "nothing on" R11's right lower leg. IDHS-S stated, "Yep, no clear documentation of that" was in R11's record. SELF ADMINISTRATION OF MEDICATION ASSESSMENT R11's record lacked an assessment of self-administration of medication for self-administration of lidocaine medication (used to treat pain). R11's MAR dated January 2023, included lidocaine cream 2.5% apply thin film to AV (fistula/a connection that is made between an artery and a vein for dialysis access) access area one hour before dialysis and cover with small square of plastic wrap and tape in place and indicated R11 self-administered the medication.	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 34 R11's Medication Management Assessment dated June 27, 2022, indicated "not applicable, plan already in place for staff to administer medications", for area of ability to self-administer medications. On January 20, 2023, at 11:27 a.m. IDHS-S stated R11 self applied the pain cream. IDHS-S reviewed R11's record and verified R11's record lacked assessment for self-administration of lidocaine medication. IDHS-S stated, "If clicked different in the assessment, it would have populated a whole self-administration of medication assessment". R18 R18's diagnoses included ataxia (impaired balance and coordination). R18's Service Plan Agreement unsigned, included daily check , housekeeping, laundry. R18's Progress Note dated January 2, 2023, indicated the licensee was to start medication administration for R18. R18's Resident Incident Report dated January 2, 2023, indicated resident stated she lost her balance in her apartment and fell into her dishwasher. She cut the inside of her mouth and hurt her left arm. She can move her arm fine, it is just sore. Nurse was informed. Asked resident to start using her walker when she is walking around, as she seems unstable with cane. R18's Progress note dated January 7, 2023, documented by IDHS-S indicated resident complained of pain to right arm after fall last week, which she had helped herself off the floor. She was wondering if she should have x-rayed. She has full range of motion (ROM) to right arm	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 35 but it is sore. R18's record lacked evidence the RN had conducted comprehensive assessment of the resident for a change in condition related to the above fall. On January 18, 2023, at 1:56 p.m. LALD-N stated she had no further information related R18's fall. R20 R20's diagnoses included urinary tract infection and diabetes. R20's Service Plan Agreement effective date December 4, 2022, unsigned, included services of COVID-19 monitoring, therapeutic exercise, bathing, meals, dressing assist, garbage removal, housekeeping, laundry, medication administration, escorts, wellness checks, toileting assist and ace wrap application and removal. R20's Fall Risk Assessment dated December 4, 2022, indicated total score of 13 (a score of 10 or more indicates risk of fall). R20's Resident Incident Report dated December 16, 2022, indicated resident stated while standing up from wheelchair, resident started to walk and got her leg caught on the wheelchair foot pedals and started to fall. Resident caught herself on the table next to her and slid on top of another resident who helped lower her to the ground located in the main dining room. R20's Progress note dated December 16, 2022, documented by IDHS-S indicated Staff checked vital signs and if client could do ROM. Two staff picked resident up from floor using gait belt. Followed up with resident and she stated that she	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 36	{01620}		

has no injury. Asked resident if there was anything else we could do for her related to the fall and she stated that she will just have to slow down.

R20's record lacked documented evidence the RN had conducted comprehensive assessment of physical assessment of R20 related to the fall.

On January 18, 2023, at 1:56 p.m. LALD-N stated she had no further information related R20's fall.

R21
R21's diagnoses included chronic obstructive pulmonary disease with (acute) exacerbation, congestive heart failure and fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue).

R21's Service Plan Agreement effective December 4, 2022, unsigned, included bathing assist, pendent check, meals, compression stocking assist, oximeter reading, temperature, weight, housekeeping, laundry, medication administration and daily checks.

R21's Resident Incident Report dated December 25, 2022, indicated resident fell asleep on the toilet and fell off. She hit her head on the floor, landed on her right shoulder and side. Bruise found on right knee, hit head, pain: head, shoulder, wrist. Called the nurse. Called 911 and sent her in.

R21's Progress note dated December 27, 2022, indicated resident returned from hospital after being admitted due to respiratory tract infection. Resident transitioned to oral antibiotics today and started on prednisone for three days. Resident states that she feels anxious to get home, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 37	{01620}		

feels she is back to her baseline. Resident oxygen level is 93 percent and vitals are stable upon return. Resident appears to be slightly short of breath, but resident reports feeling anxious due tot the transfer back to her apartment. Resident expresses no concerns at this time.

R21's Fall Risk Assessment dated December 28, 2022, indicated total score of 11 (a score of 10 or more indicates risk of fall).

R21's record lacked evidence the RN had conducted comprehensive assessment of the resident for a change in condition related to fall/readmission after hospitalization, including implementation of intervention to prevent further fall and injury.

On January 18, 2023, at 1:56 p.m. LALD-N stated she had no further information related R21's fall/readmission after hospitalization .

R3
R3's diagnoses included acute and chronic respiratory failure with hypoxia, congestive heart failure, abnormal glucose, anxiety, depression and dyspnea.

R3's Service Plan Agreement dated August 2, 2022, included meals, temperature, oximeter reading, housekeeping and laundry delivery/wash/pick up. R3's Service Plan Agreement did not include the service of medication administration.

90 DAY ASSESSMENT
R3's comprehensive assessment lacked documented evidence the RN had checked vital signs (blood pressure, temperature, pulse, respirations) and lung sounds at the time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 38 assessment. R3's 90 day assessment dated December 3, 2022, completed by RN-T indicated R3 reported weight of 227 pounds; skin integrity thin/fragile; respiratory required oxygen/self manages oxygen and nebulizer/other inhalers/shortness of breath is all of the time; does not have a cough. The assessment lacked documented evidence by the RN of vital signs checked and listening to lung sounds at the time of the assessment. On January 20, 2023, at 11:27 a.m. RN-T stated she completed R3's assessment dated December 3, 2022, face to face with R3, asked R3 what his weight was and had checked R3's vitals. RN-T stated. "No" to checking R3's lung sounds at the time of the assessment. SELF-ADMINISTRATION OF MEDICATION ASSESSMENT R3's record lacked an assessment of self administration of medications. Previous survey exited on October 21, 2022, identified on October 18, 2022, at 9:49 a.m. ULP-J was observed to administer medications to R3. At 10:10 a.m. during interview with R3, medications were observed to be in R3's apartment in the living room area. The medications were albuterol/Ventolin inhalers (provides relief for breathing difficulties), Breo inhaler (provides relief for breathing difficulties), Desenex powder (used to treat skin infections), aspercreme liquid (used for pain), Biofreeze (used for pain), Nicoderm 14 milligram (mg) patches (helps quit smoking) and diclofenac sodium 1% gel (used for pain). On January 20, 2023, at 9:35 a.m. observation of	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 39 R3's apartment from the doorway identified an inhaler medication was observed to laid on top of a end table in the living room area. On January 20, 2023, at 11:27 a.m. licensed assisted living director (LALD)-N stated, "No we do not have documentation for that", referring to self-administration of medication assessment being completed for R3. R7 R7's record lacked implementation of interventions for behaviors by the RN related to falls as indicated on R7's comprehensive assessment. R7's Service Plan Agreement dated October 19, 2022, included 90 day assessment, annual assessment, COVID-19 monitoring, therapeutic exercise/movement, activity reminder, bathroom cleaning, meals, vital signs, weight, bed making, housekeeping, laundry, medication management/administration and daily check. Previous survey exited on October 21, 2022, identified R7 had 13 falls between the dates of June 1, 2022, and October 17, 2022. R7's Progress Notes identified the following: -December 10, 2022, resident put herself on floor and wants to be sent in frequently when nothing is wrong, behavior issue. -January 4, 2023, resident had a fall on December 8, 2022. Follow up included adding preventive monitoring and encouraging resident to keep walker next to the bed. No injuries noted. Resident is seeing therapy, they were notified. Provider notified of fall. R7's 90 day assessment dated December 11,	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 40 2022, indicated resident demonstrates severe anxiety regarding medical health; behaviors listed: severe anxiety and repetitive behavior of multiple falls/frequent ER. "Will staff provide behavioral interventions: yes, behavior occurs less than daily, but could require staff intervention to prevent self harm if the behavior occurs. Requires planning for staff to know appropriate intervention." R7's Fall Risk Assessment dated December 11, 2022, indicated a total score of 13 (a score of 10 or more was risk of falls). R7's Service Checkoff List dated January 2023, lacked documented evidence of interventions addressing behaviors related to falls and interventions implemented related to falls. R7's record lacked documented evidence the RN had implemented interventions related to behaviors as indicated on R7's assessment dated December 11, 2022, to minimize the risk for future falls and potential injury. On January 20, 2023, at 11:27 a.m. LALD-N reviewed R7's record and verified R7's record lacked documented evidence of implementation of interventions for behaviors as indicated on R7's assessment. LALD-N stated, "Behaviors should have been in service agreement based on the assessment." R10 R10's record lacked evidence the RN conducted a reassessment no more than 90 calendar days from the date of the last assessment. R10's Service Plan Agreement effective August 19, 2021, indicated R10 received services including bathing, medication administration,	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 41 toileting plan, blood sugar checks, meals, laundry, and housekeeping. R3's last two assessments were requested. Assessments dated October 10, 2022, and January 18, 2023, were provided. 100 days had passed between assessments. On October 5, 2022, at 11:02 a.m. RN-B verified R3's May and August assessments were greater than 90 days apart. RN-B confirmed the electronic health record alerts them when assessments are due, and stated she and RN-E had been working on completing them timely. On January 20, 2023 at 1:23 p.m. IDHS-S confirmed R10's most recent quarterly assessment was completed late. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Assisted Living License policy dated August 1, 2021, indicated a RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required for pre-admission assessment, 14 day assessment, ongoing assessment completed periodically but no less than every 90 days and for change in condition. A RN would complete assessments as indicated by individual resident circumstances. A comprehensive assessment included but may not be limited to the requirements outlined by Minnesota rules. The RN would reassess the resident if the resident had a change in condition. The licensee's Falls Prevention and Reduction policy dated August 1, 2021, indicated the RN would incorporate any interventions to prevent or reduce falls into the residents service plan. When	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01620}	Continued From page 42 a resident experiences a fall the director of health services or designee would review the fall in an attempt to determine the root cause analysis, every fall would be reviewed and the review was to be documented in the electronic record. Nurse review notes are completed int he resident's electronic health record. Notes are made after the fall occurred, summarizing information gathered at the time of the fall and the resident's current status as it relates to the effects or potential effects of the fall and determining root cause analysis and when necessary document evaluation of interventions trialed and unsuccessful and the implementation of new intervention(s) after unsuccessful trial. No further information was provided.	{01620}		
{01640} SS=E	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. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01640}	Continued From page 43 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 revision of the service plan with changes in services for three of four residents (R3, R11, R10). 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: R3 R3's record lacked evidence of revision of the service plan with change in services. R3's diagnoses included acute and chronic respiratory failure with hypoxia, congestive heart failure, abnormal glucose, anxiety, depression and dyspnea. R3's Service Plan Agreement dated August 2, 2022, included meals, temperature, oximeter reading, housekeeping and laundry delivery/wash/pick up.	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01640}	Continued From page 44 Previous survey exited on October 21, 2022, identified on October 18, 2022, at 9:49 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R3. R3's Medication Administration Record (MAR) dated January 2023, identified the licensee's ULP were administering medications to R3. R3's Service Plan Agreement lacked revision to include the services of medication administration. On January 20, 2023, at 11:27 a.m. licensed assisted living director (LALD)-N reviewed R3's record and verified R3's service agreement was not updated to include the service of medication administration. R11 R11's diagnoses included chronic kidney disease stage 4 (severe) (dialysis recipient) and Parkinson's disease. R11's Service Plan Agreement dated August 3, 2022, included meals, COVID-19 monitoring, pendant check, vital signs, appointment reminder, garbage removal, housekeeping, laundry, medication administration and daily check. R11's Clinic note dated December 6, 2022, indicated wound care "9/14" (September 14, 2022), right sacral ulcer stage 2, left Ischial is now healed. R11's Physician Order Sheet dated January 3, 2023, included the following: -routine treatments; start date May 5, 2022, bordered foam dressing change foam dressing two times per week and as needed (PRN) when soiled	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01640}	Continued From page 45 -start date May 27, 2022, mupirocin 2% topical ointment (bactroban 2% topical ointment) (antibiotic) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. R11's Progress Note identified the following: -January 9, 2023, documented by service support coordinator (SSC)-U, indicated wound care late entry for January 3, 2023. Resident seen wound care department at clinic. Right sacral ulcer stage 2, small open area. No signs of infection. Continue bordered foam "MWF" (Monday, Wednesday, Friday) until closed. Instructed to apply barrier cream to surrounding skin. Left Ischial is now healed. Ischial pressure ulcers are also healed, but tender, dry scaling skin noted. Will ask her to apply barrier cream daily for comfort and skin protection. Will need off loading consistently. R11's Medication Administration Record dated January 2023, included the following: -boarder foam dressing change foam border dressing two times per week and as needed (PRN) when soiled -mupirocin 2% topical ointment (bactroban 2% topical ointment) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. On January 18, 2023, at 10:53 a.m. ULP-J stated R11's Medication Administration Record (MAR) included wound dressing change to be done by the ULP. ULP-J stated R11 "tells [staff] when needs changing" for the wound dressing. ULP-J stated when she changed the dressing on R11's buttock she applied mupirocin ointment to the wound and covered the area with Mepilex dressing. ULP-J stated a homecare agency was	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01640}	Continued From page 46 also changing the dressing. On January 18, 2023, at 11:05 a.m. observation of R11's buttocks identified a foam dressing was in place on R11's left buttock. Removal of the dressing by a homecare agency RN revealed an open area on R11's left buttock. R11's right buttock skin was intact and had no open areas. Homecare agency RN was observed to remove old dressing form R11's left buttock, apply Triad cream (coloplast hydrophilic wound dressing paste that keeps wound covered and protected from incontinence) to the open area and covered the open area with a Mepilex foam dressing. R11's 90 Day Assessment dated November 21, 2022, indicated "skin integrity open areas describe:". The assessment lacked documented information of open areas. R11's Change in Condition Assessment dated January 2, 2023, indicated "skin integrity open areas describe:". The assessment lacked documented information of open areas. R11's Service Plan Agreement lacked revision to include the service of wound dressing changes. On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S stated she had not looked at R11's buttocks or assessed R11's pressure wound. IDHS-S verified the licensee's ULP were providing wound dressing changes. IDHS-S reviewed R11's record and verified R11's service agreement was not updated to include the service of wound dressing changes.	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01640}	Continued From page 47 R10 R10's Service Plan Agreement effective August 19, 2021, indicated R10 received services including medication set-up - self administration. The Service Plan Agreement indicated every first Thursday the nurse will set up medications in a pill minder or caddy and give the medications to the resident. All medications are delivered by pharmacy and reviewed by a nurse. Medications are centrally stored under the RN's supervision, and set up in medication caddies by a licensed nurse for resident self administration of medications. The licensed nurse or designee was responsible for monitoring medication supplies and ensuring medication refills were ordered on a timely basis. On January 17, 2023, at 11:54 a.m. ULP-P was observed administering an insulin injection to R10. On January 20, 2023, at 9:58 a.m. ULP-P confirmed staff administered all of R10's medications and was unaware if the resident had ever had medications set-up in a medi-minder or med caddie. On January 20, 2023, at 12:44 p.m. IDHS-S confirmed R10's most recent signed Service Plan Agreement was dated August 19, 2021. IDHS-S stated though R10's Service Plan Agreement had been updated, it had not been signed by the resident or their representative as required. IDHS-S further confirmed R10 was no longer receiving medication set-up services or self-administering her medications. The licensee's Service Plan Modifications policy dated August 1, 2021, indicated when a resident received services and a change(s) to the service	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01640}	Continued From page 48 plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. If the service plan needs to be modified due to change in prescriber's order or a change in the resident's needs, the service plan modification form would be completed. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided.	{01640}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01650}	Continued From page 49 authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for two of four residents (R3, 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: R3 R3's Service Plan Agreement dated August 2, 2022, included meals, temperature, oximeter reading, housekeeping and laundry delivery/wash/pick up. In addition, the service plan indicated "Advance directives," but did not have any documented information to indicate if R3 had an advance directive or not. Previous survey exited on October 21, 2022, identified on October 18, 2022, at 9:49 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R3.	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01650}	Continued From page 50 R3's Medication Administration Record (MAR) dated January 2023, identified the licensee's ULP were administering medications to R3. R3's Service Plan Agreement lacked the following: -a description of the services to be provided, the fees for services, and the frequency of each service (for medication administration); -the identification of staff or categories of staff who will provide the service (for medication administration); and -a contingency plan that includes: the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B (living will) On January 20, 2023, at 11:27 a.m. licensed assisted living director (LALD)-N reviewed R3's record and verified R3's service agreement was not updated to include the content above. R11 R11's Service Plan Agreement dated August 3, 2022, included meals, COVID-19 monitoring, pendant check, vital signs, appointment reminder, garbage removal, housekeeping, laundry, medication administration and daily check. In addition, the service plan indicated "Advance directives," POLST (physician order for life sustaining treatment) on file but did not have any documented information to indicate if R11 had an advance directive or not. R11's Clinic note dated December 6, 2022, indicated wound care "9/14" (September 14, 2022), right sacral ulcer stage 2, left Ischial is now healed.	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01650}	Continued From page 51 R11's Physician Order Sheet dated January 3, 2023, included the following: -routine treatments; start date May 5, 2022, bordered foam dressing change foam dressing two times per week and as needed (PRN) when soiled -start date May 27, 2022, mupirocin 2% topical ointment (bactroban 2% topical ointment) (antibiotic) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. R11's Progress Note identified the following: -January 9, 2023, documented by service support coordinator (SSC)-U, indicated wound care late entry for January 3, 2023. Resident seen wound care department at clinic. Right sacral ulcer stage 2, small open area. No signs of infection. Continue bordered foam "MWF" (Monday, Wednesday, Friday) until closed. Instructed to apply barrier cream to surrounding skin. Left Ischial is now healed. Ischial pressure ulcers are also healed, but tender, dry scaling skin noted. Will ask her to apply barrier cream daily for comfort and skin protection. Will need off loading consistently. R11's Medication Administration Record dated January 2023, included the following: -boarder foam dressing change foam border dressing two times per week and as needed (PRN) when soiled -mupirocin 2% topical ointment (bactroban 2% topical ointment) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. On January 18, 2023, at 10:53 a.m. ULP-J stated R11's Medication Administration Record (MAR) included wound dressing change to be done by	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01650}	Continued From page 52 the ULP. ULP-J stated R11 "tells [staff] when needs changing" for the wound dressing. ULP-J stated when she changed the dressing on R11's buttock she applied mupirocin ointment to the wound and covered the area with Mepilex dressing. ULP-J stated a homecare agency was also changing the dressing. R11's Service Plan Agreement lacked the following: -a description of the services to be provided, the fees for services, and the frequency of each service (for wound dressing changes); -the identification of staff or categories of staff who will provide the service (for wound dressing changes); and -a contingency plan that includes: the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B (living will) On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S stated she had not looked at R11's buttocks or assessed R11's pressure wound. IDHS-S verified the licensee's ULP were providing wound dressing changes. IDHS-S reviewed R11's record and verified R11's service agreement did not include the content above. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated the resident service plans would include the required content according to 144G.70 Subd. 4. (f). No further information was provided.	{01650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01690	Continued From page 53	01690		
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure notification of physician,	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01690	Continued From page 54 investigation and corrective actions for medication errors for two of two residents (R16, R17). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Medication Incident Reports indicated the following: -January 6, 2023, R16 was not administered oxcarbazepine (used to control partial seizures) 600 mg. The report lacked documented evidence R16's physician was notified, outcome to resident and the "incident investigation" area lacked documentation addressing areas for narrative investigation, possible contributing factors and corrective actions taken. -January 6, 2023, R17 was not administered ibuprofen (used to reduce inflammation/pain) 600 mg. The report lacked documented evidence R17's physician was notified, outcome to resident and the "incident investigation" area lacked documentation addressing areas for narrative investigation, possible contributing factors and corrective actions taken. On January 18, 2023, at 8:55 a.m. licensed assisted living director (LALD)-N stated she could not find any further documented information for the above medication errors.	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01690	Continued From page 55 The licensee's Medication Errors policy dated August 1 2021, indicated the director of health services (RN) or nurse in charge would immediately investigate any medication errors and would implement and document corrective actions to reduce the risk of similar medication errors in the future, the RN would determine the potential harm to the client and would contact the appropriate providers. No further information was provided.	01690		
{01700} SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent	{01700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01700}	Continued From page 56	{01700}		

diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure assessment of medication management services included all required content for three of five residents (R3, R11, R10).

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:

R3
R3's diagnoses included acute and chronic respiratory failure with hypoxia, congestive heart failure, abnormal glucose, anxiety, depression and dyspnea.

R3's Service Plan Agreement dated August 2, 2022, included meals, temperature, oximeter reading, housekeeping and laundry delivery/wash/pick up. The service plan lacked the service of medication administration.

Previous survey exited on October 21, 2022, identified on October 18, 2022, at 9:49 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01700}	Continued From page 57 unlicensed personnel (ULP)-J was observed to administer medications to R3. Previous survey exited on October 21, 2022, identified on October 18, 2022, at 10:10 a.m. R3 stated the licensee's staff provided the services of medication administration. During the interview, the following medications were observed in R3's living room: albuterol/Ventolin inhalers (provides relief for breathing difficulties), Breo inhaler (provides relief for breathing difficulties), Desenex powder (used to treat skin infections), aspercreme liquid (used for pain), Biofreeze (used for pain), Nicoderm 14 milligram (mg) patches (helps quit smoking) and diclofenac sodium 1% gel (used for pain). On January 20, 2023, at 9:35 a.m. observation of R3's apartment from the doorway identified an inhaler medication was observed to laid on top of a end table in the living room area. R3's MAR dated January 2023, indicated staff administered one medication used for anxiety, two used for supplement, two used to treat high blood pressure, one used to prevent blood clots, one used to treat depression, one used to reduce fluid in the body, one used to treat movements in face/tongue/or other body parts that cannot be controlled, one used to treat low potassium levels, one used to treat multiple myeloma (cancer), one used to treat schizophrenia/bipolar disorder, one used to treat infections, three used to help breathing, one used for virus infections, three used to treat pain, one used to treat diarrhea and one used to treat skin condition (itchy or red irritation). R3's Medication Management Assessment was dated December 3, 2022. The assessment	{01700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01700}	Continued From page 58	{01700}		

included "indications for use of known medications medications reviewed with resident and family per MAR found in resident chart."
R3's medication assessment did not address the following required content:
-identification of all medications the resident is known to be taking (which medications R3 had in apartment and was self administering);
-indications for medications

R11
R11's diagnoses included chronic kidney disease stage 4 (severe) (dialysis recipient) and Parkinson's disease.

R11's Service Plan Agreement dated August 3, 2022, included medication administration.

On January 18, 2023, at 10:53 a.m. ULP- J was observed to administer medications to R11.

R11's MAR dated January 2023, indicated staff administered one medication used to treat mental health condition, two used to treat allergies, two used for depression, three used for supplement, one used for Parkinson's disease, four used for infection, one used for muscle relaxant, one used to prevent blood clots, five used for pain, one used for hormone replacement, one used for dry eyes, one used to treat low blood pressure, one used to treat stomach acid, one used to treat high cholesterol, one used to reduce fluid in the body, two used to help breathing, one used for itching/sleep, one used for dry mouth, one used for cough, two used for constipation, one used to treat loose stool, one used for anxiety, one used for migraine, one used for skin rash/irritation and one used for headache.

R11's Medication Management Assessment was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01700}	Continued From page 59 dated June 27, 2022. The assessment did not reference another document regarding a list of medications reviewed for the assessment. R11's medication assessment did not address the following required content: -identification of all medications the resident is known to be taking; -identification of indications for medications; -identification of side effects; R10 R10's diagnoses included diabetes, chronic kidney disease, hypertension, hyperlipidemia (high cholesterol), narcolepsy (a sleep disorder that makes people very drowsy during the day), constipation, and osteoarthris of bilateral knees. R11's signed Service Plan Agreement dated August 19, 2021, included meals, assistance with bathing, blood sugar checks, toileting plan, laundry, and medication set-up. The plan did not include medication administration. On January 17, 2023, at 11:47 a.m. ULP-P was observed to administer insulin to R10. R10's MAR dated January 2023, indicated staff administered three medications used for hypertension, three medications for diabetes, one medication for hyperlipidemia, one medication for narcolepsy, four supplements, one medication for pain, and one medication for constipation. R10's Medication Management Assessment was dated January 18, 2023. The assessment did not reference another document regarding a list of medications reviewed for the assessment. R10's medication assessment did not address the following required content: -identification of all medications the resident is	{01700}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01700}	Continued From page 60 known to be taking; -identification of indications for medications; and -identification of side effects On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S reviewed R3, R11, and R10's records and verified R3, R11, and R10's medication management assessments lacked the above information. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Assisted Living License policy dated August 1, 2021, indicated a RN would complete assessments as indicated by individual resident circumstances. A comprehensive assessment included but may not be limited to the requirements outlined by Minnesota rules. The policy further indicated medication review including over the counter medications, prescription medications and supplements would include self-administration versus other type of administration. No further information was provided.	{01700}		
{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 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01730}	Continued From page 61 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 ensure an individualized medication management plan included all required content for two of five residents (R3, R11). This practice resulted in a level two violation (a	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01730}	Continued From page 62	{01730}		

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:

R3
R3's Service Plan Agreement dated August 2, 2022, indicated services included three meals daily, temperature daily, oximeter reading daily, housekeeping weekly, laundry wash, pick up and delivery once weekly. The service plan lacked the service of medication administration.

Previous survey exited on October 21, 2022, identified on October 18, 2022, at 9:49 a.m. unlicensed personnel (ULP)-J was observed to administer medications to R3.

Previous survey exited on October 21, 2022, identified on October 18, 2022, at 10:10 a.m. R3 stated the licensee's staff provided the services of medication administration. During the interview, the following medications were observed in R3's living room: albuterol/Ventolin inhalers (provides relief for breathing difficulties), Breo inhaler (provides relief for breathing difficulties), Desenex powder (used to treat skin infections), aspercreme liquid (used for pain), Biofreeze (used for pain), Nicoderm 14 milligram (mg) patches (helps quit smoking) and diclofenac sodium 1% gel (used for pain).

On January 20, 2023, at 9:35 a.m. observation of R3's apartment from the doorway identified an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01730}	Continued From page 63 inhaler medication was observed to laid on top of a end table in the living room area. R3's MAR dated January 2023, indicated staff administered one medication used for anxiety, two used for supplement, two used to treat high blood pressure, one used to prevent blood clots, one used to treat depression, one used to reduce fluid in the body, one used to treat movements in face/tongue/or other body parts that cannot be controlled, one used to treat low potassium levels, one used to treat multiple myeloma (cancer), one used to treat schizophrenia/bipolar disorder, one used to treat infections, three used to help breathing, one used for virus infections, three used to treat pain, one used to treat diarrhea and one used to treat skin condition (itchy or red irritation). R3's record/MAR lacked parameters for hours apart combivent, loperamide (four times a day as needed) and triamcinolone ointment (twice daily as needed); lacked parameters for which PRN medication to administer first for shortness of breath (albuterol or combivent) and for pain (diclofenac sodium gel or Tylenol); and lacked specific direction when the nurse should be notified when a problem arises with medication management services. R3's individualized medication management record lacked the following: -documentation of specific resident instructions relating to the administration of medications; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services R11	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01730}	Continued From page 64 R11's Service Plan Agreement dated August 3, 2022, included medication administration. On January 18, 2023, at 10:53 a.m. ULP-J was observed to administer medications to R11. R11's MAR dated January 2023, indicated staff administered one medication used to treat mental health condition, two used to treat allergies, two used for depression, three used for supplement, one used for Parkinson's disease, four used for infection, one used for muscle relaxant, one used to prevent blood clots, five used for pain, one used for hormone replacement, one used for dry eyes, one used to treat low blood pressure, one used to treat stomach acid, one used to treat high cholesterol, one used to reduce fluid in the body, two used to help breathing, one used for itching/sleep, one used for dry mouth, one used for cough, two used for constipation, one used to treat loose stool, one used for anxiety, one used for migraine, one used for skin rash/irritation and one used for headache. R11's record/MAR lacked parameters for hours apart for: Ativan (used for anxiety) (twice daily as needed)/nystatin (used to treat skin infections) as needed/triamcinolone cream (used to treat skin rash/irritation) twice daily as needed/nystatin cream three times a day as needed; lacked parameters which medication to use first for migraine/headache (as needed Nurtec/Ubrelvy); lacked parameters for which to use first for constipation (as needed gavilax/senna-s); parameters for which to use first for breathing (albuterol as needed/combivent as needed), and lacked specific direction when the nurse should be notified when a problem arises with medication management.	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01730}	Continued From page 65 R11's individualized medication management record lacked the following: -documentation of specific resident instructions relating to the administration of medications; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S reviewed R3 and R11's records and verified R3 and R11's individualized medication management record lacked the above information. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated the RN may delegate to unlicensed personnel the task of providing administration of medications if before performing the procedures the RN has developed written specific instruction for each resident. The licensee's Administration and Documentation of PRN Medications dated August 21, 2021, indicated the RN would review prescriptions to ensure that the prescription clearly identified symptoms for which the PRN was prescribed, the frequency that the PRN may be administered, and other pertinent information. If the parameters of the PRN were unclear, the RN would follow up with the prescriber to obtain the necessary clarification. The RN would document in the resident's medication MAR the PRN medication name, symptoms for which the PRN medication may be administered, when the supervising nurse needs to be notified and whether staff should check back with the resident following administration to determine if the PRN was effective.	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01730}	Continued From page 66 The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, indicated the RN would provide specific instructions for administering PRN medications, consistent with the prescriber's prescription for the reason/circumstances under which the PRN's may be administered. No further information was provided.	{01730}		
{01760} SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication was administered as prescribed for one of five residents (R11) and failed to ensure the amount of sliding scale insulin administered was documented for two of two residents (R4, R10).	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01760}	Continued From page 67 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: R11 The licensee failed to stop administration of a medication as prescribed. R11's Physician Order Sheet dated January 3, 2023, included Nystatin 100,000 units/ml (per milliliter) suspension - swish and spit 5 ml by mouth twice daily for 48 days, start date of November 21, 2022. On January 18, 2023, at 10:53 a.m. unlicensed personnel (ULP)- J was observed to administer medications to R11. ULP-J administered Nystatin suspension 5 ml to R11. R11's MAR dated January 2023, included Nystatin 100,000 units/ml suspension - swish and spit 5 ml by mouth twice daily for 48 days with effective date of November 21, 2022. R11 continued to receive the Nystatin medication after day 48 (January 7, 2023) (11 days past day 48). On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S reviewed R11 records and verified R11's was being	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01760}	Continued From page 68	{01760}		

administered the Nystatin suspension. IDHS-S versified there was no end date inputted on R11's MAR for the Nystatin medication. IDHS-S stated she would "have to look into" the prescriber's order for the Nystatin.
R4
R4's diagnoses included type 2 diabetes, history of falls, anxiety, depression, and chronic kidney disease.

R4's service plan dated July 29, 2022, indicated R4 received services to include medication administration.

R4's Medication Administration Record (MAR) dated January 2023, included Humalog (insulin) 100 unit/milliliters (ml), inject six units subcutaneous three times daily with meals along with sliding scale.
The sliding scale was written when blood sugars (BS) were in a certain range, additional Humalog insulin was added to the base amount of six units.
The scale was written as:
BS 180-219 + two units
BS 220-259 + three units
BS 260-299 + four units
BS 300-339 + five units
BS 340-379 + six units
BS 380-399 + seven units
greater than 399 call MD

R4's MAR included areas for staff to input their initials when additional units of Humalog insulin were administered, but failed to indicate how many additional units of insulin were administered to R4.

R10
R10's diagnoses included type two diabetes mellitus with diabetic chronic kidney disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01760}	Continued From page 69 R10's Service Plan Agreement dated August 19, 2021, indicated R10 received services including bathing, medication administration, toileting plan, blood sugar checks, meals, laundry, and housekeeping. R10's physician orders dated January 3, 2023, included an order for Novolog Flexpen insulin, inject per sliding scale three times daily with meals. The sliding scale was written when blood sugars (BS) were in a certain range; the scale was written as: BS 180-219 + two units BS 220-259 + three units BS 260-299 + four units BS 300-339 + five units BS 340-379 + six units BS 380-399 + seven units greater than 399 call provider On January 17, 2023, at 11:54 a.m. unlicensed personnel ULP-P was observed performing a blood sugar check and administering insulin for R10. R10's BS measured 183; ULP-P then injected two units of insulin into R10's right lower abdomen. On January 18, 2023, at 9:35 a.m. ULP-P stated for "some" of the residents with sliding scale insulin they document how many units are given. ULP-P reviewed the eMAR and confirmed for R10 and R4 they do not record how many units are given when administering sliding scale insulin. On January 20, 2023, at 1:23 p.m. interim director of health service (IDHS)-S confirmed the units of sliding scale insulin administered for R4 and R10 were not documented in the resident record.	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01760}	Continued From page 70 The licensee's Documentation of Medication, Treatment, and Therapy Management Services policy dated August 1, 2021, indicated staff would document each task immediately after that tasks has been performed. Documentation would follow professional standards for documentation. The nurse would document actions to implement a new prescription when received. No further information was provided.	{01760}		
{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; (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	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01940}	Continued From page 71 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 ensure prepare and include a treatment plan to include all required content for one of two 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: R11's diagnoses included chronic kidney disease stage 4 (severe) (dialysis recipient) and Parkinson's disease. R11's Service Plan Agreement dated August 3, 2022, included meals, COVID-19 monitoring, pendant check, vital signs, appointment reminder, garbage removal, housekeeping, laundry, medication administration and daily check. The Service Plan Agreement lacked the service of wound dressing changes. R11's Clinic note dated December 6, 2022, indicated wound care "9/14" (September 14, 2022), right sacral ulcer stage 2, left Ischial is	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01940}	Continued From page 72 now healed. R11's Physician Order Sheet dated January 3, 2023, included the following: -routine treatments; start date May 5, 2022, bordered foam dressing change foam dressing two times per week and as needed (PRN) when soiled -start date May 27, 2022, mupirocin 2% topical ointment (bactroban 2% topical ointment) (antibiotic) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. R11's Progress Note identified the following: -January 9, 2023, documented by service support coordinator (SSC)-U, indicated wound care late entry for January 3, 2023. Resident seen wound care department at clinic. Right sacral ulcer stage 2, small open area. No signs of infection. Continue bordered foam "MWF" (Monday, Wednesday, Friday) until closed. Instructed to apply barrier cream to surrounding skin. Left Ischial is now healed. Ischial pressure ulcers are also healed, but tender, dry scaling skin noted. Will ask her to apply barrier cream daily for comfort and skin protection. Will need off loading consistently. R11's Medication Administration Record dated January 2023, included the following: -boarder foam dressing change foam border dressing two times per week and as needed (PRN) when soiled -mupirocin 2% topical ointment (bactroban 2% topical ointment) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. On January 18, 2023, at 10:53 a.m. unlicensed	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01940}	Continued From page 73	{01940}		

personnel (ULP)- J stated R11's Medication Administration Record (MAR) included wound dressing change to be done by the ULP. ULP-J stated R11 "tells [staff] when needs changing" for the wound dressing. ULP-J stated when she changed the dressing on R11's buttock she applied mupirocin ointment to the wound and covered the area with Mepilex dressing. ULP-J stated a homecare agency was also changing the dressing.

R11's record lacked an individualized treatment/therapy management record for the treatment of wound dressing changes for pressure ulcer left buttock including the following:
-a statement of the type of services that would be provided;
-documentation of specific resident instructions relating to the treatments or therapy administration;
-identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and
-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.

On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S stated she had not looked at R11's buttocks or assessed R11's pressure wound. IDHS-S verified the licensee's ULP were providing wound dressing changes. IDHS-S reviewed R11's record and verified R11's individualized treatment/therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01940}	Continued From page 74 management record lacked the above information for wound dressing changes. The licensee's Treatment and Therapy Management Plan policy dated August 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident and would contain the required content according to 144G.72 Subd. 3. No further information was provided.	{01940}		
{01950} SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01950}	Continued From page 75 by: Based on observation, interview, and record review, the licensee failed to ensure an the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records for one of four residents (R11); and had instructed the unlicensed personnel in the proper methods with respect to each resident and five of five unlicensed personnel (ULP-G, ULP-H, ULP-I, ULP-J, ULP-P) has demonstrated the ability to competently follow the procedures. 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: R11's diagnoses included chronic kidney disease stage 4 (severe) (dialysis recipient) and Parkinson's disease. R11's Service Plan Agreement dated August 3, 2022, included meals, COVID-19 monitoring, pendant check, vital signs, appointment reminder, garbage removal, housekeeping, laundry, medication administration and daily check. The Service Plan Agreement lacked the service of wound dressing changes. R11's Physician Order Sheet dated January 3, 2023, included the following:	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01950}	Continued From page 76 -routine treatments; start date May 5, 2022, bordered foam dressing change foam dressing two times per week and as needed (PRN) when soiled -start date May 27, 2022, mupirocin 2% topical ointment (bactroban 2% topical ointment) (antibiotic) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. R11's Medication Administration Record dated January 2023, included the following: -boarder foam dressing change foam border dressing two times per week and as needed (PRN) when soiled -mupirocin 2% topical ointment (bactroban 2% topical ointment) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. On January 18, 2023, at 10:53 a.m. unlicensed personnel (ULP)-J stated R11's Medication Administration Record (MAR) included wound dressing change to be done by the ULP. ULP-J stated R11 "tells [staff] when needs changing" for the wound dressing. ULP-J stated when she changed the dressing on R11's buttock she applied mupirocin ointment to the wound and covered the area with Mepilex dressing. ULP-J stated a homecare agency was also changing the dressing. R11's record for wound dressing changes lacked clear direction for frequency of dressing changes, lacked direction for cleansing of the wound and lacked clear direction for where the foam dressing and mupirocin were to be applied. ULP TRAINING AND DEMONSTRATED COMPETENCY	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01950}	Continued From page 77 ULP-G had a hire date of September 20, 2022. ULP-H had a hire date of August 17, 2021. ULP-I had a hire date of December 28, 2021. ULP-J had a hire date of November 1, 2000. ULP-P had a hire date of August 26, 2022. ULP-G, ULP-H, ULP-I, ULP-J and ULP-P's records lacked documented evidence for training and demonstrated competency for providing the treatment service of R11's wound dressing changes. On January 18, 2023, at 1:03 p.m. ULP-D stated the licensee's med passer ULP would complete wound dressing changes for R11. ULP-D stated the ULP med passers were not trained or competency evaluated for specific wound dressing changes for R11. The ULP would have basic wound dressing change training and competency only. On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S verified the licensee's ULP were providing wound dressing changes and a homecare agency was providing wound dressing changes. IDHS-S reviewed R11's record and verified R11's prescriber orders for wound dressing changes and mupirocin would need to be clarified with the physician. IDHS-S verified R11's record lacked documented specific instructions for the delegated treatment services of wound dressing changes. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated unlicensed	{01950}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01950}	Continued From page 78 personal that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN. The RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or delegate administration of medications, treatment and therapy if the ULP has satisfied the training requirements of demonstrated ability to completely follow the procedures, the RN has developed written, specific instruction for each resident and the RN has documented that the ULP have been trained and have demonstrated competency to follow the procedures. No further information was provided.	{01950}		
{01970} SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure clear prescriber's orders for treatment or therapy for three of three residents (R8, R11, R10) and failed to ensure a prescriber's order for treatment for one of four residents (R5). This practice resulted in a level two violation (a	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01970}	Continued From page 79 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: R8 R8's physician orders dated December 2, 2022, included blood glucose monitoring - "RA [resident assistant] will check residents blood sugar 4X/day [four times per day] right before meals and PRN [as needed]. Notify nurse if below 70 or above 300. If below 70, give snack. Apply gloves. Have resident wash hands with soap and water. Remove her glucometer from the drawer and remove a strip from the canister. Put a new lancet in her lancet device and hand unit to her. She will press the button and put a drop of blood on the strip. Have her remove the lancet from the lancet device and place it in the sharps. Record the blood sugar. Return equipment to her drawer. If blood sugar below 90 or above 350 notify the nurse. 9 AM, 12 PM, 5 PM, 8 PM, PRN Indicated For Type 2 diabetes mellitus with unspecified complications. On January 18, 2023, at 8:12 a.m. unlicensed personnel (ULP)-G was observed to check R8's blood sugar. R8's prescriber's order for blood sugar checks lacked clear direction for parameters when to notify the nurse for low and high blood sugar readings.	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01970}	Continued From page 80 On January 20, 2023, at 11:32 p.m. licensed assisted living director (LALD)-N reviewed R8 and R10's blood sugar orders with the two different parameters and agreed the orders were confusing and would need clarification from the physician. R11 R11's Physician Order Sheet dated January 3, 2023, included the following: -routine treatments; start date May 5, 2022, bordered foam dressing change foam dressing two times per week and as needed (PRN) when soiled -start date May 27, 2022, mupirocin 2% topical ointment (bactroban 2% topical ointment) (antibiotic) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. R11's Medication Administration Record dated January 2023, included the following: -boarder foam dressing change foam border dressing two times per week and PRN when soiled -mupirocin 2% topical ointment (bactroban 2% topical ointment) apply small amount to bilateral buttock ulcers with dressing changes. Changing dressing three times a week. On January 18, 2023, at 10:53 a.m. ULP-J stated R11's Medication Administration Record (MAR) included wound dressing change to be done by the ULP. ULP-J stated R11 "tells [staff] when needs changing" for the wound dressing. ULP-J stated when she changed the dressing on R11's buttock she applied mupirocin ointment to the wound and covered the area with Mepilex dressing. ULP-J stated a homecare agency was	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01970}	Continued From page 81 also changing the dressing. On January 18, 2023, at 11:05 a.m. observation of R11's buttocks identified a foam dressing was in place on R11's left buttock. Removal of the dressing by a homecare agency RN revealed an open area on R11's left buttock. R11's right buttock skin was intact and had no open areas. Homecare agency RN was observed to remove old dressing form R11's left buttock, apply Triad cream (coloplast hydrophilic wound dressing paste that keeps wound covered and protected from incontinence) to the open area and covered the open area with a Mepilex foam dressing. R11's prescriber orders for wound dressing changes lacked clear direction for frequency of dressing changes, lacked direction for cleansing of the wound and lacked clear direction for where the foam dressing and mupirocin were to be applied. On January 20, 2023, at 11:27 a.m. interim director of health services (IDHS)-S verified the licensee's ULP were providing wound dressing changes and a homecare agency was providing wound dressing changes. IDHS-S reviewed R11's record and verified R11's prescriber orders for wound dressing changes and mupirocin would need to be clarified with the physician. R10 R10's diagnoses included type two diabetes mellitus with diabetic chronic kidney disease. R10's Service Plan Agreement, effective August 19, 2021, indicated R10 received services including bathing, medication administration, toileting plan, blood sugar checks, meals, laundry, and housekeeping.	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01970}	Continued From page 82 R10's physician orders dated January 3, 2023, included the following treatment order: Blood Glucose Monitoring - RA will check residents blood sugar twice daily and PRN. Notify nurse if below 70 or above 300. If below 70, give snack. Apply gloves. Have resident wash hands with soap and water. Remove her glucometer from the drawer and remove a strip from the canister. Put a new lancet in her lancet device and hand unit to her. She will press the button and put a drop of blood on the strip. Have her remove the lancet from the lancet device and place it in the sharps. Record the blood sugar. Return equipment to her drawer. If blood sugar below 90 or above 350 notify the nurse. 9 AM, 12 PM, 8 PM Indicated For Type 2 diabetes mellitus with unspecified complications. R5 R5's diagnoses included lupus anticoagulation syndrome (an autoimmune disorder that causes blood clots to form in various parts of the body), thrombosis (blood clot) of deep veins of unspecified lower extremity and history of pulmonary embolism (blood clot in the lung) with long term anticoagulation management. R5's unsigned service plan effective January 18, 2023, indicated R5 received services to include compression stocking assistance. R5's Physician Order Sheet signed December 20, 2022, did not include an order for compression stockings. On January 19, 2022, at 12:16 p.m. IDHS-S reviewed R5's record and confirmed there was no evidence of a physician order for compression stockings.	{01970}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{01970}	Continued From page 83 On January 19, 2023, at 3:08 p.m. R5 was observed seated in recliner in her apartment with compression stockings on her lower legs. On January 20, 2023, at 11:32 p.m. LALD-N reviewed R8 and R10's blood sugar orders with the two different parameters and agreed the orders were confusing and would need clarification from the physician. The licensee's Medication and Treatment Orders policy dated August 2021, indicated the RN was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. The order for treatment must contain the name of the resident, a description of the treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. No further information was provided.	{01970}		
{03000} SS=D	626.557 Subd. 3 Timing of report (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	{03000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{03000}	Continued From page 84 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 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	{03000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{03000}	Continued From page 85 (MAARC) suspected maltreatment for one of one resident (R12). 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: R12's diagnoses included bipolar disorder. R12's unsigned Service Plan Agreement effective July 21, 2022, indicated the resident received services including medication administration, blood glucose checks, meals, and housekeeping. The MAARC report submitted January 9, 2023, at 14:14 (2:14 p.m.), indicated on January 7, 2023, at 3:10 p.m. a resident assistant (RA) reported that registered nurse (RN)-Q, was verbally aggressive and made threatening statements towards a resident under her care. The encounter took place in a community area of the building and was witnessed by staff and other residents. The incident caused the resident to breakdown into tears and was emotionally distraught. The RA reporting the incident followed the resident (R12) back to her room where he proceeded to provide care and emotional support for a half hour. The nurse (RN-Q) has been put on suspension pending further investigation. The MAARC report was submitted 49 hours after the alleged allegation.	{03000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	R 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
{03000}	Continued From page 86 On January 17, 2023, at 1:20 a.m. licensed assistant living director (LALD)-N confirmed the MAARC Report for R12 was reported greater than 24 hours after occurrence. LALD-N stated the incident was reported by an unlicensed personnel (ULP) to an interim RN who then made the report to LALD-N, greater than 24 hours after it occurred. LALD-N further stated the alleged perpetrator, RN-Q, was the nurse working at the time of the incident and should have self-reported. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult would report the incident immediately to their "LALD" (licensed assisted living director), director of health services or designee and that person would complete an incident report. If the incident appears to be suspected abuse, neglect or financial exploitation, the LALD, director of health services or designee would immediately report to the "CEP" (common entry point). No further information was provided.	{03000}		

Electronically Delivered

November 23, 2022

Administrator
Vista Praire Monarch Meadows
2135 Lor Ray Drive
North Mankato, MN 56003

RE: Project Number(s) SL30703015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 21, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that

consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring = $3,000
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000

The total amount you are assessed is $6,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30703015 On October 17, 2022, through October 21, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were 82 residents; all of whom were receiving services under the provider's Assisted Living license. On October 21, 2022, the immediacy of correction orders 2310 has been removed; however, non-compliance remains at a level 3, pattern (H).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 17, 2022, at 11:31 a.m. executive director (ED)-A and registered nurse/organizational director of Health Care (RN/ODOHC)-B stated the licensee's	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 250	Continued From page 3 employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 250	Continued From page 4	0 250		

conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective
process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 250	Continued From page 5 attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent on May 9, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of June 23, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - handling complaints regarding staff or services provided by staff; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; - conducting appropriate screenings, or	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 250	Continued From page 6 documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals; As a result of this survey, the following orders were issued 0510, 0550, 0620, 0660, 1440, 1530, 1620, 1700, 1730, 1750, 1760, 1790, 1820, 1940, 1950, 1960, 1970, 2310 and 3000 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 470	Continued From page 7 available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted as required, potentially affecting the licensee's current residents, staff and any visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license, and at the time of the survey had a census of 82 residents. Building A On October 18, 2022, at 12:42 p.m. observation	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 470	Continued From page 8	0 470		

of the facility with registered nurse/organizational director of health care (RN/ODOHC)-B identified the staffing schedule posted for building A was posted in the entrance way and was not posted in a central location (residents and staff would have to go through entrance doors to view). RN/ODOHC-B verified the schedule was not posted in a central location inside of building A.

On October 18, 2022, at 12:47 p.m. observation of the facility with executive director (ED)-A identified the staffing schedule posted for building A was posted in the entrance way and was not posted in a central location (residents and staff would have to go through entrance doors to view). ED-A then moved the staffing schedule for building A from the entrance way of building A inside building A in a central area where other information for residents was posted.

Building B
On October 17, 2022, at 1:00 p.m. during the facility tour in building B, the surveyor observed a schedule posted on the wall outside of the nurse's office. The staff schedules were dated from October 14, 2022, through October 16, 2022. The schedule did not reflect the staff working on October 17, 2022. Registered nurse (RN)-C was reported out ill.

On October 19, 2022, at 11:45 a.m. unlicensed personnel (ULP)-D stated normally the receptionist in building A would post the daily staffing plan on the wall in building A, and the RN posted the schedule outside of the nurse's office in building B.

On October 20, 2022, at approximately 1:00 p.m. RN-C stated she was out ill on October 17, 2022, and it was not recognized the schedule needed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 470	Continued From page 9 be posted. RN-C stated there was not a clear back up plan for her absence, and a plan would need to be created to meet this requirement. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated August 1, 2021, indicated the daily work schedule would be posted in a central location in each building of a facility, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 480	Continued From page 10 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 included document titled, Food and Beverage Establishment Inspection Report dated October 17, 2022, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 485	Continued From page 11 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; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a menu a week in advance that was made available to all residents. 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: The licensee's facility had two attached buildings, each with a dining room. On October 17, 2022, the facility's census was 82 residents. On October 17, 2022, during observation of noon meal service in building A and building B, the current day's menu was posted on a white board hanging on a wall in each dining room. No other menu postings were observed.	0 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 485	Continued From page 12 On October 18, 2022, during observation of breakfast meal service in building A, the current day's menu was posted on a white board on a wall in each dining room. No other menu postings were observed. On October 18, 2022, at 9:30 a.m. cook (C)-F stated the chef managed the weekly menu and printed out multiple copies of that week's menu to be placed in a designated clear plastic holder in each dining room and were available for residents to take. This was usually done each Monday morning. Additionally C-F stated there were "rate your meal cards" available for residents to provide feedback regarding the meals. C-F verified there were no weekly menus posted in either building. The licensee's Food Service and Menu Planning (12.01) dated August 2021, indicated Menus would be prepared at least one (1) week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 510	Continued From page 13 applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to handwashing during treatment and medication administration for three of six residents (R2, R8, 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 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: R2 On October 18, 2022, at 8:08 a.m. R2 laid in bed and was observed to have a urostomy (right side abdomen) and nephrostomy tubes on right and left sides (kidney areas). Unlicensed personnel (ULP)-G and ULP-I entered R2's room with gloves on. ULP-G cleansed the urostomy drain spout of R2's catheter drainage bag and drained the urine into a container. ULP-I poured the urine from the container into the toilet. ULP-I's gloves remained on.	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 510	Continued From page 14 -ULP-G and ULP-I failed to wash hands upon entering R2's room and ULP-I failed to remove gloves and wash hands after assisting with the catheter. ULP-G wiped the nephrostomy drain spout of catheter drainage bag and drained the contents into a container. With the same gloves, ULP-G wiped the drain spout (already being drained by ULP-I) with the same alcohol pad while the contents of the bag was draining out of the spout. ULP-G removed gloves and applied new gloves. ULP-G removed dressing from left nephrostomy site. The surveyor intervened and asked ULP-G to wash hands. ULP-G stated, "Even though I have new gloves on. I didn't know that." ULP-G washed hands with soap and water. ULP-G applied gloves, cleansed around the site with an alcohol pad. ULP-G folded a 4 x 4 gauze pad in half and placed the folded gauze underneath the tube and secured it with tape. ULP-I assisted to hold the dressing while ULP-G taped into place. ULP-G removed gloves and washed hands. ULP-I removed gloves and applied clean gloves. -ULP-G failed to remove gloves and wash hands after cleansing around the nephrostomy site. ULP-I failed to wash hands after removal of gloves. With gloves on, ULP-D removed the dressing from right side nephrostomy tube site, cleansed around the site with acetic acid using a gauze pad, used scissors to cut a slit into a non-stick pad, placed the non-stick pad around the tube site and secured the pad with tape. ULP-D removed the dressing from around the right tube site which ULP-G had applied, cleansed around the site with the same gauze (with acetic acid on it) and applied a split non-stick dressing secured with tape around the site. ULP-D put away	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 510	Continued From page 15	0 510		

supplies and removed gloves. ULP-D applied gloves.
-ULP-D failed to wash hands upon entering R2's room, failed to remove gloves and wash hands between sites, after removal of soiled dressing and cleansing the sites, failed to use a clean gauze pad to cleanse around left nephrostomy site, failed to cleanse scissors after using to remove soiled dressing (prior to using scissors to cut slit in clean gauze pad) and failed to wash hands after removing gloves.

ULP-D cleansed R2's peri area in the front and ULP-I cleansed R2's buttocks area with disposable wipes. With the same soiled gloves, ULP-D and ULP-I assisted R2 to finish dressing and transferred R2 into a wheelchair using a Hoyer (full body mechanical lift). ULP-D removed gloves and walked down the hallway carrying gloves. ULP-I's gloves remained on.
-ULP-D and ULP-I failed to remove gloves and wash hands after providing peri cares.

R8
On October 18, 2022, at 9:15 a.m. ULP-H was observed to wash hands, apply gloves and obtain R8's medications from the medication cart. With the same gloves, ULP-H walked to R8's apartment, administered oral medications, checked R8's blood sugar, administered eye drop medication and insulin via an insulin pen. ULP-H walked out of R8's room with gloves on.
-ULP-H failed to remove gloves and wash hands upon entering R8's apartment, between procedures, and after leaving R8's apartment.

R1
On October 19, 2022, at 8:43 a.m. ULP-D was observed to check R1's blood sugar and provide wound treatment to R1's left and right lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 510	Continued From page 16	0 510		

extremities, hernia area over umbilical area, coccyx area and right and left buttocks. ULP-D entered R1's apartment and applied gloves. ULP-D checked R1's blood sugar. ULP-D removed gloves, touched a walkie talkie and then washed their hands.
-ULP-D failed to wash hands before applying gloves and failed to wash their hands after removal of gloves.

ULP-D applied gloves and assisted R1 to transfer from wheelchair to bed. ULP-D removed gloves and applied clean gloves.
-ULP-D did not wash hands after removing gloves.

ULP-D removed ace wrap (compression wrap) and wound dressing from R1's left lower leg/foot. R1's left foot was observed to have an open area on the side of the little toe and a closed black colored area on the side of great toe. ULP-D cleansed R1's left lower leg/foot with acetic acid. With the same gloves, ULP-D taped two abdominal (ABD) pads (absorbent pad) together around R1's lower leg and wrapped gauze cling wrap around the lower left foot/leg.
-ULP-D failed to remove gloves and wash hands after removing soiled dressings and cleansing areas, prior to applying clean dressings.

With the same gloves, ULP-D removed two ace wraps and wound dressings from R1's right lower leg/foot. R1's right foot was observed to have an open area on the side of the little toe and R1's upper outer right lower leg had an intact blister. ULP-D removed a Mepilex dressing (antimicrobial foam dressing) from the outer side of R1's foot. The skin was intact underneath the dressing. ULP-D cleansed R1's lower right leg/foot with acetic acid. ULP-D removed gloves and washed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 510	Continued From page 17	0 510		

hands. ULP-D applied clean gloves and applied a Mepilex dressing to the right outer blister on R1's upper lower leg and outer side of R1's right foot, taped three smaller ABD pads together around R1's lower leg and wrapped gauze cling wrap around the lower right foot/leg.

With the same gloves, ULP-D applied one ace wrap spirally around to R1's left and right lower foot/leg. ULP-D asked R1 if she wanted her to change the dressing to her "belly button" area. ULP-D removed gloves and applied clean gloves. ULP-D removed Mepilex dressing from the area. The skin was intact. ULP-D cleansed the skin with acetic acid and applied a Mepilex dressing.
-ULP-D failed to wash hands after removing gloves and failed to remove gloves and wash hands after removing dressing and cleansing area, prior to applying clean dressings.

With the same gloves, ULP-D had R1 roll over in bed. A foam white pad dressing was in place on R1's right buttock and left buttock. ULP-D removed the white foam pad from R1's right buttocks. The skin underneath the foam pad was open. R1's coccyx area had no dressing in place. ULP-D asked R1 if the Mepilex dressing fell off the coccyx area. ULP-D stated the open area on R1's coccyx has "gotten worse". ULP-D cleansed the coccyx area with a dry disposable pad cloth. ULP-D stated "I can put my finger in hole" while placing fingertip of index finger into the area. ULP-D applied thick moisture barrier paste to R1's coccyx wound. ULP-D removed the white foam pad from R1's left buttock. The skin underneath the foam pad was open. ULP-D removed gloves.
-ULP-D failed to remove gloves and wash hands between the open areas, prior to applying barrier cream and failed to wash hands after removal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 510	Continued From page 18 gloves following applying barrier cream. ULP-D called registered nurse RN-C into R1's room. RN-C came into R1's room and ULP-D informed RN-C R1's coccyx area had "a hole now." R1 stated regarding her buttocks and coccyx areas "It's so sore." ULP-D applied clean gloves and stated to RN-C "I put my finger in there" referring to the wound on R1's coccyx. ULP-D showed RN-C how deep the coccyx wound hole was by finger depth of using her index finger. ULP-D applied a big, padded dressing which covered both buttocks and coccyx areas. ULP-D removed gloves. -ULP-D failed to remove gloves and wash hands prior to applying clean dressing and after removal of gloves after applying clean dressing. ULP-D applied gloves, put away supplies, transferred R1 back into the wheelchair, removed gloves and pushed R1 in wheelchair out of apartment. -ULP-D failed to wash hands after removal of gloves. On October 19, 2022, at 1:29 p.m. RN-C stated she would expect staff to wash hands upon entering a resident's room, remove gloves and wash hands between procedures/between sites/after peri cares, wash hands when gloves are removed, remove gloves and wash hands anytime dirty to clean, and wash hands before leaving a resident's apartment. RN-C stated she would expect scissors to be cleansed with an alcohol pad when soiled. RN-C stated she world expect a clean gauze pad to be used to cleanse around both nephrostomy tube sites. The licensee's Handwashing policy dated August 1, 2021, indicated handwashing would be	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 510	Continued From page 19 performed between resident cares and whenever direct physical contact with resident take place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: before and after direct contact with resident, if moving from a contaminated body site to a clean body site during care and after removing gloves or gowns. The licensee's Delegated Nursing Tasks: Wound Care Clean Dressing Change undated, indicated hands should be washed at the start of the procedure, gloves should be removed and hands washed after current dressing was removed, after cleansing the wound and after applying clean dressing. After applying creams/ointments as ordered apply fresh gloves if needed. The licensee's Delegated Nursing Task with Medications: Eye Drop/Ointment undated, indicated wash hands and apply gloves before administering the eye drops and after administering the eye drops. The licensee's Delegated Nursing Task with Medications: Blood Glucose Monitoring undated, indicated wash hands and apply gloves before checking the blood sugar and after checking the blood sugar. The licensee's Delegated Nursing Task with Medications: Insulin Injection: Pen undated, indicated wash hands and apply gloves before administering the insulin and after administering the insulin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include: -information about the facilities' grievance procedure;	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 550	Continued From page 21 -the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances; and -the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center On October 18, 2022, at 12:42 p.m. observation of the facility with registered nurse/organizational director of health care (RN/ODOHC)-B identified no posted facility grievance procedure was observed in any area of the facility. On October 18, 2022, at 12:47 p.m. observation of the facility with executive director (ED)-A identified no posted facility grievance procedure was observed in any area of the facility. The licensee's Complaint/Grievance Posting policy dated August 2021, indicated the licensee would post, in a conspicuous place, the information about the licensee's complaint/grievance procedure, including the required content as above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults;	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 620	Continued From page 22 abuse prevention plan. (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. 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) a significant medication error for one of one resident (R9). 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: R9's Service Plan Agreement unsigned, included medication setup and administration. R9's clinic note dated May 17, 2022, indicated results/data for anticoagulation management on May 12, 2022, for INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) was "2.2" and "anticoag [anticoagulation] dosing goal INR" was "2.0 - 3.0". Continue warfarin (used to prevent blood clots) 8 milligrams (mg) daily.	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 620	Continued From page 23 R9's Medication Incident Report dated June 2, 2022, indicated "resident was to be given a 6 mg tablet and a 2 mg tablet to equal 8 mg total. Medication was to be held on 5/26/22 [May 26, 2022] and the INR was to be redrawn. New order was to be started upon new dosage obtained from pharmacy. Medication was not given on 5/28/22-5/30/22 [May 28, 2022, through May 30, 2022]. Resident assistant working on 5/31/22 [May 31, 2022] administered medication correctly upon finding medication in medication room. Resident went to prescheduled clinic visit on 6/2/22 [June 2, 2022] for INR recheck and it was noted to be '1.2'. Clinic staff contacted nurse to discuss results and it was at that time determined that the resident had indeed missed 3 scheduled doses. Resident remained asymptomatic throughout duration of incident. Medication dose has been adjusted to address current concerns." R9's Medication Administration Record dated May 2022, identified the licensee's staff were administering medications to R9. On October 21, 2022, at 1:44 p.m. registered nurse (RN)-C stated regarding R9 not receiving coumadin for three doses, "Yes, definitely a significant med error". RN-C stated she would "look" to see if the incident was reported to MAARC; however, no further information was provided. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult would report the incident immediately to their "LALD" (licensed assisted living director), director of health services or designee and that person would complete and	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 620	Continued From page 24 incident report. If the incident appears to be suspected abuse, neglect or financial exploitation, the LALD, director of health services or designee would immediately report tot he "CEP" (common entry point). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults for five of five residents (R1, R2, R3, R4, R5).	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 630	Continued From page 25 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: R1 began receiving services on June 29, 2022. On October 19, 2022, at 8:43 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and provide wound dressing changes to R1's left and right lower extremities, umbilical area, coccyx area and right and left buttocks. ULP-D removed ace wrap (long stretch bandages used for compression) from both of R1's lower legs/feet. R1's Individualized Abuse Prevention Plan (IAPP) dated June 29, 2022, indicated for "able to report abuse or neglect" the resident was not vulnerable in this area. The plan failed to address R1's susceptibility to abuse by another individual, including other vulnerable adults and R1's risk of abusing other vulnerable adults. On October 21, 2022, at 11:30 a.m. registered nurse (RN)-C verified R1's IAPP lacked an assessment of R1's susceptibility to abuse by another individual, including other vulnerable adults and R1's risk of abusing other vulnerable adults. R2	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 630	Continued From page 26 R2 began receiving services on July 28, 2022. On October 18, 2022, at 8:08 a.m. ULP-G, ULP-I and ULP-D were observed to provide nephrostomy tube (a plastic tube passed from the back, through the skin and kidney to the point where urine collects) site care (right and left sides), empty drainage bag for nephrostomy sites, empty drainage bag for urostomy observed to be located on R2's right side abdomen area, assist R2 with hygiene/dressing and transfer R2 using sling and Hoyer lift. R2's IAPP dated July 28, 2022, indicated for "able to report abuse or neglect" the resident was not vulnerable in this area. The plan failed to address R2's susceptibility to abuse by another individual, including other vulnerable adults, R2's risk of abusing other vulnerable adults and lacked signature by and RN for completion of assessment of R2's vulnerabilities. On October 21, 2022, at 12:48 p.m. RN-C verified R2's IAPP lacked assessment of R2's susceptibility to abuse by another individual, including other vulnerable adults and R2's risk of abusing other vulnerable adults. R3 R3 began receiving services on May 10, 2022. On October 18, 2022, at 9:49 a.m. ULP-J was observed to administer medications to R3. R3's IAPP dated May 10, 2022, indicated for "able to report abuse or neglect" the resident was not vulnerable in this area and resident does not appear to pose a threat to other vulnerable adults. The plan failed to address R3's susceptibility to abuse by another individual,	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 630	Continued From page 27 including other vulnerable adults. On October 21, 2022, at 1:19 p.m. RN-C verified R3's IAPP lacked assessment of R3's susceptibility to abuse by another individual, including other vulnerable adults. R4 R4 began receiving services on January 31, 2022. On October 18, 2022, at approximately 8:00 a.m. ULP-E was observed to provide a blood sugar check, oral medications, and an insulin injection to R4. On October 21, 2022, licensee provided R4's IAPP created and signed by RN-C, was dated October 19, 2022. R4's plan failed to address R4's susceptibility to abuse by another individual, including other vulnerable adults. On October 21, 2022, at approximately 11:35 a.m. RN-C verified R4's IAPP had not been completed since the time R4 moved in, and was completed by RN-C on October 19, 2022, and also verified R4's IAPP lacked the required content. R5 R5 began receiving services on August 1, 2022. On October 18, 2022, at approximately 8:45 a.m. ULP-E was observed to provide R5 oral medications, toileting assistance, and coccyx wound check. R5's plan dated December 27, 2021, failed to	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 630	Continued From page 28 address R5's susceptibility to abuse by another individual, including other vulnerable adults. On October 21, 2022, at approximately 11:35 a.m. RN-C verified R5's IAPP lacked the required content. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated an abuse prevention plan would be completed for each resident in the assisted living by day 14 after move-in or receipt of services. Additionally, the plan would be based upon an individualized review or assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults and the resident's risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 640	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 17 residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 18, 2022, at 12:42 p.m. observation of the facility with registered nurse/organizational director of health care (RN/ODOHC)-B identified no 911 emergency number or the required MAARC information was posted in common areas. On October 18, 2022, at 12:47 p.m. observation of the facility with executive director (ED)-A identified no 911 emergency number or the required MAARC information was posted in common areas. No further information was provided.	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 640	Continued From page 30 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 660	Continued From page 31 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: The licensee's TB facility risk assessment dated December 18, 2020, indicated the licensee was a low risk. TB PLAN/EDUCATION The licensee's TB Prevention and Control policy dated August 1, 2021, indicated "h. If a case of suspected or confirmed TB disease is identified among staff or residents, we assure that appropriate actions will be taken immediately which may include assistance with agreement for transfer of the resident to an inpatient facility while collaborating and cooperating with local and public health and MDH [Minnesota Department of Health]." The licensee lacked a written TB infection control plan for the procedures to address early recognition, isolation and referral for handling residents with suspected or confirmed active TB; therefore, none of the licensee's employees had received training on their role in the procedure. On October 21, 2022, at 1:19 p.m. registered nurse (RN)-C verified the licensee's TB policy lacked a written TB infection control plan for the procedures to address early recognition, isolation and referral for handling residents with suspected or confirmed active TB. TB SCREEN AND TESTING	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 660	Continued From page 32 ULP-H Unlicensed personnel (ULP)-H had a hire date of August 17, 2021, and provided direct care and services to the licensee's residents. On October 18, 2022, at 9:02 a.m. ULP-H was observed to administer medications to R2. ULP-H's record lacked documented evidence of TB screen and two step Tuberculin Skin Testing (TST) upon hire. On October 19, 2022, at 1:15 p.m. executive director (ED)-A stated he "could not find" TB screening or TST for ULP-H. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should have an up-to-date TB infection control program that included: Written TB infection control procedures; Health care worker (HCW) education. A TB infection control program should include the following: written TB infection control procedures. Procedures should address: Early recognition: All health care workers should know the signs and symptoms of TB and their role in their facility's TB infection control program. Isolation: Place a potentially infectious TB patient in an airborne infection isolation (AII) room if available; If not, place patient in separate room with door shut. Referral: If your setting does not handle TB patients, transfer potentially infections TB patients to a setting that is equipped to evaluate and treat TB patients. TB training is required at time of hire for all health care workers and the content should focus on basic	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 660	Continued From page 33 information: Your health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. Two-step TST Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. The licensee's TB Prevention and Control policy dated August 1, 2021, indicated at time of hire and prior to contact with residents, a: assisted living employees would be screened for TB, including TB symptom screen and a two-step skin test or single blood test (interferon gamma release assay). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 730	Continued From page 34 medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of content in the resident's record as required for five of five residents (R1, R2, R3, R4, R5).	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 730	Continued From page 35 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: R1 R1's record lacked documented information for emergency contact and medical service providers. R1's Face Sheet printed October 18, 2022, included an emergency contact name and phone number, but lacked the address and phone number for the emergency contact listed; included medical doctor (MD) name and phone number, but lacked the address of the MD listed; included the name and phone number for the pharmacy, but lacked the address of the pharmacy listed; and included the name of hospital preference and transportation, but lacked the address and telephone number for the hospital and transportation preferences listed. R2 R2's record lacked documented information for legal representatives, and designated representative and medical service providers. R2's Face Sheet printed October 18, 2022, included a name and phone number for a case worker and responsible party, but lacked the address for the persons listed; and included the	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 730	Continued From page 36 name and phone number for the pharmacy, but lacked the address of the pharmacy listed. R3 R3's record lacked documented information for emergency contact, designated representative and medical service providers. R3's Face Sheet printed October 18, 2022, included emergency contact and case manager names and phone numbers, but lacked the address for the persons listed; included name and phone number for the pharmacy, but lacked the address of the pharmacy; and included the name of hospital preference and transportation, but lacked the address and telephone number for the hospital and transportation preferences listed. On October 21, 2022, at 11:30 a.m. registered nurse (RN)-C verified R1, R2 and R3's records lacked the above. The licensee's Resident Record Information and Content policy dated August 2021, indicated the resident record "must include" the name, addresses, and telephone numbers of the resident's emergency contact, legal representatives, designated representative and the resident's health and medical service providers, if known. R4 R4's diagnoses included type 2 diabetes. R4's service plan dated July 29, 2022, indicated R4 received medication administration. R4's MAR dated October 2022, indicated ULP provide blood sugar checks four times daily and to notify nursing staff when R4's blood sugar was below 90 or above 350.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 730	Continued From page 37 On October 18, 2022, at approximately 8:00 a.m. ULP-E was observed to provide a blood sugar check, oral medications, and insulin injection to R4. R4's document labeled Blood Sugar dated October 2022, indicated the blood sugar readings were out-of-range for the following dates and times: October 2, 2022, at 12:11 p.m. (448); October 9, 2022, at 11:52 a.m. and 7:42 p.m. (407); October 11, 2022, at 11:37 a.m. (439); October 15, 2022, at 7:26 p.m. (352) and; October 18, 2022, at 11:46 a.m. (410). R4 record lacked documentation that the ULP notified a nurse regarding out of range blood sugars, and the record lacked follow up documentation by the nurse. In addition, R4's Face Sheet lacked complete content to include contact addresses, hospital preference, transportation, funeral home, and durable medical equipment. On October 21, 2022, at 11:20 a.m. registered nurse (RN)-C stated the ULP have called her when R4's blood sugars were out of range, but there was not a designated location outside of the Blood Sugar document for ULP to document their notification. RN-C also verified she had not completed documentation of the notifications provided by ULP. Additionally, RN-C verified the above noted missing face sheet content. R5 R5's service plan dated August 11, 2022,	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 730	Continued From page 38 indicated R5 received services to include medication administration, dressing assist of one, TED (thromboembolism deterrent) assistance, denture assistance, wound care, Covid-19 monitoring (with oxygen saturation check twice daily), meals, laundry, and housekeeping. R5's record labeled Service Checkoff List dated October 2022, lacked documentation of receiving services to include the following: Oxygen Saturation check a.m.: October 1, 2, 3, 6, 7, 10-17, 2022; Oxygen Saturation check p.m.: October 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 15, 16, 2022; Dressing assistance a.m.: October 1, 3, 6, 7, 10, 11, 13, 14, 16, 2022; Dressing assistance p.m.: October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 2022; Behavior management/redirection a.m.: October 1, 3, 6, 7, 10, 11, 13, 14, 16, 2022; Compression stockings on a.m.: October 1, 3, 6, 7, 10, 11, 13, 14, 16, 2022; Compression stockings off p.m.: October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 2022; Denture assist a.m.: October 1, 3, 6, 7, 10, 11, 13 14, 16, 2022; Denture assist p.m.: October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 2022; Garbage removal a.m.: October 1, 3, 6, 7, 10, 11, 12, 13, 14, 16, 2022; Garbage removal p.m.: October 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,13, 15, 16, 2022; Refill water mug a.m.: October 1, 2, 3, 5, 6, 9, 10, 11, 12, 2022; Laundry pick up, wash and delivery: October 6, 13, 2022; Linen change: October 6, 13, 2022; Verify attendance at breakfast: October 1, 2, 6, 7, 10, 11, 13, 14, 16, 2022; Pendant check: October 6, 13, 2022;	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 730	Continued From page 39 Temperature check a.m.: October 1, 2, 3, 6, 7, 10, 11, 12, 13, 14, 15, 16, 2022; Bed making: October 1, 3, 6, 7, 10, 11, 13, 14, 16, 2022; Verify attendance at lunch: October 1, 3, 6, 7, 10, 11, 13, 14, 16, 2022; Reminder to put oxygen on before bed: October 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 2022; Temperature check p.m.: October 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 2022; and Verify attendance at supper: October 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 15, 15, 16, 2022 R5's record lacked evidence of service documentation monitoring or reconciliation by the licensee. On October 21, 2022, at 2:00 p.m. RN-C stated her expectation was for the ULP to document the services they had completed and to further document if/when a service was not completed, or the resident refused or completed herself. RN-C stated she was not aware of a method or plan to monitor and ensure services were completed and documented. The licensee's Documentation of Medication, Treatment, and Therapy Management Services (MED-3.0) policy dated August 1, 2021, read staff will document each task immediately after that task was performed. The licensee's Medication and Treatment Orders policy (7.20) dated August 2021, indicated the licensed nurse would review all medication and treatment orders and services on a regular basis. A resident's MAR and TAR (treatment administration record) would be audited regularly by licensed nurse or designee for documentation compliance.	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 730	Continued From page 40 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 810	Continued From page 41 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on October 18, 2022, at approximately 10:20 a.m. with Executive Director (ED)-A and Maintenance Manager (MM)-K on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. During interview, ED-A and MM-K verified that the fire safety and evacuation plan for the facility lacked these provisions.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 810	Continued From page 42 Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, ED-A and MM-K verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, MM-K stated that the licensee did not have documentation or a policy on employee training. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only drills conducted by the licensee were 3/31/22, 6/30/22, and 9/22/22 with no further drills being documented. During interview, MM-K verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 920	Continued From page 43 the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee's contract included a disclosure of the category of assisted living facility license held by the facility for five of five residents (R1, R2, R3, R4, R5). 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: The licensee had an assisted living license effective August 1, 2021, and renewed on August	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 920	Continued From page 44 1, 2022. R1's Assisted Living Contract was signed June 29, 2022. R2's Assisted Living Contract was signed July 28, 2022. R3's Assisted Living Contract was signed July 1, 2022. R4's Assisted Living Contract was signed July 1, 2022. R5's Assisted Living Contract was signed July 1, 2022. The contracts identified on page 2. the licensee "is an assisted living facility with dementia care licensed by the Minnesota Department of Health". The licensee's Assisted Living Contract being provided to all residents lacked accurate disclosure of the category of assisted living facility license held by the facility and lacked disclosure that the licensee does not hold an assisted living facility with dementia care license. On October 21, 2022, at 3:28 p.m. executive director (ED)-A verified the contract being provided to all residents of the facility did not disclose the category of assisted living facility license held by the facility, which was an assisted living license, and did not disclose the licensee did not hold an assisted living facility with dementia care license. No further information was provided. TIME PERIOD FOR CORRECTION:	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 920	Continued From page 45 Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R1, R2, R3, R4, R5). 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	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 930	Continued From page 46 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living license effective August 1, 2021, and renewed on August 1, 2022. R1's Assisted Living Contract was signed June 29, 2022. R2's Assisted Living Contract was signed July 28, 2022. R3's Assisted Living Contract was signed July 1, 2022. R4's Assisted Living Contract was signed July 1, 2022. R5's Assisted Living Contract was signed July 1, 2022. The contracts identified on page page 18. 1. Complaint Procedure/Nondiscrimination "Questions, concerns and complaints should be addressed first with the appropriate staff person in charge of the area about which resident has a question, concern or complaint. If the matter remains unresolved, resident or resident's responsible person should contact the LALD" (licensed assisted living director). The contract further referenced the licensee's "Resident Handbook" indicating by signing the contract you agree to abide by the handbook. The licensee's Resident Handbook indicated on page 18. Complaint Resolution "please see your	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 930	Continued From page 47 lease agreement, section 18, for information on complaint procedure/nondiscrimination. Customer concern feedback forms are available throughout the community and from the business office and may be placed in the suggestion box, given to the business office staff, or mailed to: Resident Complaints". The licensee's contract lacked the name and contact information of the person representing the facility who was designated to handle and resolve complaints. On October 21, 2022, at 3:28 p.m. executive director (ED)-A verified the contract provided to all residents of the facility did not address the name and contact information of the person representing the facility who was designated to handle and resolve complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 940	Continued From page 48 people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R1, R2, R3, R4, R5). 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).	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 940	Continued From page 49 The findings include: The licensee had an assisted living license effective August 1, 2022. R1's Assisted Living Contract was signed June 29, 2022. R2's Assisted Living Contract was signed July 28, 2022. R3's Assisted Living Contract was signed July 1, 2022. R4's Assisted Living Contract was signed July 1, 2022. R5's Assisted Living Contract was signed July 1, 2022. R1, R2, R3, R4 and R5's Assisted Living Contract lacked the following required content: -whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. On October 21, 2022, at 3:28 p.m. executive director (ED)-A stated he would need to check further if the contract for all residents included the above content. No further information was provided by ED-A. No further information was provided.	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 940	Continued From page 50 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 970 SS=C	144.50 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 82 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 included: The licensee had an assisted living license effective August 1, 2021, and was renewed August 1, 2022.	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 970	Continued From page 51 R1's Assisted Living Contract was signed June 29, 2022. R2's Assisted Living Contract was signed July 28, 2022. R3's Assisted Living Contract was signed July 1, 2022. R4's Assisted Living Contract was signed July 1, 2022. R5's Assisted Living Contract was signed July 1, 2022. The Assisted Living Contract included the following: -page eighteen (18) Indemnification "resident will indemnify and hold harmless provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident". -page nineteen (19) Liability "provider is not liable to resident" for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident. Provider is also not liable for any injury, death or damage occurring as the result of resident's receipt of health-related, supportive or other services from third party providers. Provider may be liable to resident for its own negligent actions or those of its employees or agents. Unless	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
0 970	Continued From page 52 caused by one of the afore mentioned excepted reasons, resident agrees to hold provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment unit or on provider's premises. On October 21, 2022, at 3:28 p.m. executive director (ED)-A verified the licensee's Residence and Services Agreement for all residents included the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01440	Continued From page 53 performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the facility for two of three unlicensed personnel (ULP-H, ULP-I). 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: ULP-H and ULP-I's records lacked documented evidence of a registered nurse (RN) supervising ULP-H and ULP-I performing delegated tasks. ULP-H had a hire date of August 17, 2021. On October 18, 2022, at 9:02 a.m. ULP-H was observed to administer medications to R2. ULP-H's record included a 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks dated February 4, 2022, which indicated ULP-H was competent for multiple	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01440	Continued From page 54 delegated tasks. ULP-I had a hire date of December 28, 2021. On October 18, 2022, at 8:08 a.m. ULP-I was observed to assist to provide nephrostomy tube (a plastic tube passed from the back, through the skin and kidney to the point where urine collects) site care (right and left sides), empty drainage bag for nephrostomy sites, empty drainage bag for urostomy observed to be located on R2's right side abdomen area, assist R2 with hygiene/dressing and transfer R2 using sling and Hoyer lift. ULP-I's record included a 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks dated February 4, 2022, which indicated ULP-I was competent for multiple delegated tasks. On October 21, 2022, at 2:47 p.m. ULP-D stated ULP-H and ULP-I's 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks dated February 4, 2022, was the RN documented competency for medication administration tasks, and was not a 30-day supervision task. RN-C and ULP-D verified ULP-H and ULP-I's records lacked documented evidence of supervision by the RN for performing delegated tasks. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, indicated supervision of ULP by an RN would be direct supervision of the staff performing the delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks.	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01440	Continued From page 55 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01530	Continued From page 56	01530		

review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I) received the required amount of dementia care training.

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:

ULP-G
ULP-G had a hire date of September 20, 2022, and provided direct care and services to the licensee's residents.

On October 18, 2022, at 8:08 a.m. ULP-G was observed to provide R2's nephrostomy tube (a plastic tube passed from the back, through the skin and kidney to the point where urine collects) site care (right and left sides), empty drainage bag for nephrostomy sites and empty drainage bag for urostomy.

ULP-G's record included dementia training signed by executive director (ED)-A on September 22, 2022, for the following:
-Dementia 1 - Introduction and Overview 1.0 hours
-Dementia 2 - Communication 1.25 hours
-Dementia 3 Activities of Daily Living 1.0 hours
-Dementia 4 - Behaviors vs Symptoms 1.0 hours
-Dementia 5 - The Journey 0.75 hours

ULP-G's record lacked evidence of at least eight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01530	Continued From page 57	01530		

hours of initial dementia care training within 160 working hours of employment start date, and the required topic of person-centered planning and service delivery.

ULP-H
ULP-H had a hire date of August 17, 2021, and provided direct care and services to the licensee's residents.

On October 18, 2022, at 9:02 a.m. ULP-H was observed to administer medications to R2.

ULP-H's record included dementia training signed by ED-A on December 22, 2021, for the following:
-Dementia 1 - Introduction and Overview 1.0 hours
-Dementia 2 - Communication 1.25 hours
-Dementia 3 Activities of Daily Living 1.0 hours
-Dementia 4 - Behaviors vs Symptoms 1.0 hours
-Dementia 5 - The Journey 0.75 hours

ULP-H's record lacked evidence of at least eight hours of initial dementia care training within 160 working hours of employment start date, and the required topic of person-centered planning and service delivery.

ULP-I
ULP-I had a hire date of December 28, 2021, and provided direct care and services to the licensee's residents.

On October 18, 2022, at 8:08 a.m. ULP-I was observed to assist to provide nephrostomy tube (a plastic tube passed from the back, through the skin and kidney to the point where urine collects) site care (right and left sides), empty drainage bag for nephrostomy sites, empty drainage bag for urostomy observed to be located on R2's right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01530	Continued From page 58 side abdomen area, assist R2 with hygiene/dressing and transfer R2 using sling and Hoyer lift. ULP-I's record included dementia training signed by ED-A on January 10, 2022, for the following: -Dementia 1 - Introduction and Overview 1.0 hours -Dementia 2 - Communication 1.25 hours -Dementia 3 Activities of Daily Living 1.0 hours -Dementia 4 - Behaviors vs Symptoms 1.0 hours -Dementia 5 - The Journey 0.75 hours ULP-I's record lacked evidence of at least eight hours of initial dementia care training within 160 working hours of employment start date and the required topic of person-centered planning and service delivery. On October 21, 2022, at 1:19 p.m. ULP-D and registered nurse (RN)-C verified ULP-G, ULP-H and ULP-I's records lacked documented evidence of at least eight hours of initial dementia care training within 160 working hours of employment start date, and the required topic of person-centered planning and service delivery. ULP-D stated the documented dementia training noted above was the training the licensee assigned to be completed for dementia training upon hire. The licensee's Dementia Training policy dated August 2021, indicated direct care employees would complete eight hours of initial training within 160 hours of the employment start date and the training would include the required topics per 144G.64 subd. (5). No further information was provided.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01530	Continued From page 59 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) had completed and/or documented a comprehensive assessment for change in condition (wounds, emergency room (ER) visits, readmission following hospitalization,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 60	01620		

falls) for six of six residents (R1, R2, R3, R7, R4, R5) and failed to ensure the RN completed and/or documented comprehensive assessment and/or monitoring and reassessment for initial/14 day and 90 day as required for five of five residents (R1, R2, R3, R4, R5).

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 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:

R1
R1's start of care date for services was June 29, 2022.

R1's diagnoses included Type 2 diabetes mellitus with other circulatory complications, cellulitis of right and left lower limb, acute kidney failure, morbid (severe) obesity and lymphedema.

R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including annual assessment, 90 day assessment, bathing, meals, dressing, skin care (the resident assistant will verbally report any changes to the skin such as open areas, drainage or redness to the nurse. The nurse will review the results at least every 90 days to update the prescriber as indicated), bed making, garbage removal, housekeeping, linen change, laundry delivery, laundry wash, laundry pick up, medication management and administration and incontinence care/toileting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 61 ASSESSMENT OF WOUNDS R1's record lacked documented evidence of comprehensive nursing assessments by the RN for pressure ulcers/wounds (size, appearance, odor, drainage, pain) upon admission, upon readmission, and with development of new pressure ulcers/wounds. On October 18, 2022, at 8:43 a.m. R1 stated a "wound nurse" comes to the facility "two times a week on Monday and Friday" to provide "wound cares." R1 stated she had "cellulitis" in both legs, and she had two open areas on the right leg and one open area on the left leg. R1 stated she had "one big and one small joined" wound on her bottom. On October 19, 2022, at 8:43 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and provide wound dressing changes to R1's left and right lower extremities, umbilical area, coccyx area and right and left buttocks. ULP-D removed ace wrap (compression wrap) and wound dressing from R1's left lower leg/foot. R1's left foot was observed to have an open area on the side of the little toe and a closed black colored area on the side of great toe. ULP-D cleansed R1's left lower leg/foot with acetic acid (used for the treatment of infections of skin), taped two abdominal (ABD) pads (absorbent pad) together around R1's lower leg and wrapped gauze cling wrap around lower left foot/leg. R1 stated staff had bumped her toe. ULP-D removed two ace wraps and wound dressing from R1's right lower leg/foot. R1's right foot was observed to have an open area on the side of the little toe and R1's upper outer right side lower leg had an intact blister. Scant purple colored bruising was noted on top of R1's right foot and top end of R1's	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 62	01620		

great toe. ULP-D stated she noticed the blistered area last Friday. ULP-D removed a Mepilex dressing (antimicrobial foam dressing) from the outer side of R1's foot. The skin was intact underneath the dressing. ULP-D stated about two weeks ago the skin area under the Mepilex on R1's outer right side of foot was blistered and opened. ULP-D stated R1 had lymphedema. ULP-D cleansed R1's lower right leg/foot with acetic acid, applied a Mepilex dressing to the right outer blister on R1's upper lower leg and outer side of R1's right foot, taped three smaller ABD pads together around R1's lower leg and wrapped gauze cling wrap around lower right foot/leg. ULP-D applied one ace wrap spirally around to R1's left and right lower foot/leg. ULP-D asked R1 if she wanted her to change the dressing to her "belly button" area. ULP-D removed Mepilex dressing from the area. The skin was intact. ULP-D cleansed the skin with acetic acid and applied a Mepilex dressing. ULP-D had R1 roll over in bed. A foam white pad dressing was in place on R1's right buttock and left buttock. ULP-D removed the white foam pads from R1's right and left buttocks. The skin underneath the foam pads was open. R1's coccyx area had no dressing in place. ULP-D asked R1 if the Mepilex dressing fell off the coccyx area. ULP-D stated the open area on R1's coccyx "has gotten worse". ULP-D cleansed the coccyx area with a dry disposable pad cloth. ULP-D stated "I can put my finger in hole" while placing tip of index finger into the area. ULP-D applied thick moisture barrier paste to R1's coccyx wound. ULP-D called registered nurse RN-C into R1's room. RN-C came into R1's room and ULP-D informed RN-C R1's coccyx area had "a hole now." R1 stated regarding her buttocks and coccyx areas "It's so sore." ULP-D stated to RN-C "I put my finger in there" referring to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 63 wound on R1's coccyx. ULP-D showed RN-C how deep the coccyx wound hole was by finger depth of using her index finger. ULP-D applied a large, padded dressing which covered both buttocks and coccyx areas. ULP-D showed surveyor two previous open areas on R1's right thigh and one on back left thigh which she stated were present when R1 was admitted but were now healed. A sheet of paper was noted to be in R1's room to be orders for "wound care: leg, abdomen, foot, coccyx, buttocks, leg, foot. Prevention of pressure: abdomen. Mixed etiology: buttock and coccyx" dated September 16, 2022. ULP-D stated at the time "they aren't current orders. I looked at the MAR [medication administration record] before coming in" (to R1's room). R1 stated, regarding inquire if RN-C was coming into R1's room to observe wounds and measure the areas, "I don't think so". ULP-D stated upon admission R1 had the open areas to the "thigh" areas and "smaller one top back buttocks" (higher up on coccyx). ULP-D stated the umbilical area and leg areas were ongoing on and off. ULP-D stated the open areas on R1's right/left buttocks, coccyx and toe areas were all new after admission and R1 had no cellulitis to lower extremities when she was admitted. ULP-D stated directions for wound treatment to the areas on R1's left/right lower feet/legs/buttocks and coccyx were located on the MAR. ULP-D stated, "Staff do the best they can with how trained", regarding providing wound dressing changes to the above areas. ULP-D stated the wound dressing changes were to be completed daily. ULP-D stated regarding who measured R1's wound areas "I'm assuming the wound care nurse" (referring to an outside agency assisting with wound care). R1's record included the following information provided by the licensee related to wounds:	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 64 -June 29, 2022, VPC Assessment - admission or pre-move in indicated for body systems "skin integrity requires skin care assist: lotion to lower extremities and skin checks. Details of services related to skin care were provided in service plan." R1's Service Plan Agreement dated June 29, 2022, (unsigned) related to skin were bathing "RA [resident assistant] will observe skin when assisting with bathing, report any concern (open, rash, redness, swelling) to the nurse. Dressing: RA will observe skin problems when providing assistance with dressing, report any concerns to the nurse." -June 29, 2022, Progress Note "Admitted today. Has history of falls and recurrent UTI's [urinary tract infections]." -July 1, 2022, Progress Note "wound care - writer called clinic department of wound care to get written wound care instructions faxed over to us for residents open wounds." -July 1, 2022, home care agency wound care dressing instruction sheet - right abdomen, right buttock, right thigh - wash wound with wound cleanser or shower, apply skin prep to skin around the wound, cover with bordered foam, change dressing twice a week. Continue with compression as previously ordered. -July 8, 2022, Progress note wound care - seen at clinic department of wound care. Orders to "DC" (discontinue) Kerlix (gauze wrap) and ace wrap to legs. Apply moisturizer and tubi grip and short stretch wraps. She should lie down with legs elevated twice daily for one hour. Dressing: cleanse with wound cleanser, use skin prep and bordered foam. For lower leg edema tubi [compression wrap] grip to knee then short	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 65 stretch wrap NOT ACE to knee. Ace to thighs from knee to groin. Dressings should be changed "M, W, F" (Monday, Wednesday, Friday). Homecare agency to assist with wound care. -July 13, 2022, Progress Note wound care - seen by home care agency for wound care. Cares were completed to all "5" (five) wounds. M/W/F visits. Please only use short stretch wraps overs tubi to "LE" (left extremity). Lotion LE daily. -July 14, 2022, Progress Note PT (physical therapy) seen by at clinic. Start lymphedema therapy four times weekly at clinic. -July 21, 2022, Progress Note wound care seen at clinic department of wound care on July 8, 2022, for recheck of bilateral legs and buttock. Left thigh: large amount serous drainage, likely from lymphedema. Small open area with large amount of drainage, but no signs of infection. Foam dressing applied. Right posterior thigh ulcer: stage 3 on lateral thigh. No signs infection. Bordered foam applied. Most likely due to pressure from chair. She has been sitting in her chair for long periods of time. Change bordered foam every two days. PT/OT (physical/occupation therapy) evaluations for seating recommendations in process. Bilateral ischium: pressure ulcers notes, stage 3 on right, stage 2 on left. Topical treatment ordered with a bordered foam dressing, these can be changed three times a week and as needed. This is most likely caused by her wheelchair, complicated by obesity and immobility. In process of getting new wheelchair and cushion. Advised to get out of wheelchair more often by laying down in bed or recliner. Left hand and arm: edema noted, pitting in hand especially. Start compression with tubigrip that is encompassing her thumb and hand. Encourage	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 66	01620		

elevation and movement to decrease edema. Skin folds right axilla: Interdry applied. Will ask AL (assisted living) to apply and change every five days. Venous Insufficiency/lymphedema: will need ongoing compression and elevation. Today we discontinued the ABD. Kerlix roll was falling down. Does have Velcro compression garments could transition into with tubigrip underneath for the under garment. Today we applied short stretch wraps over tubigrip. Wound measurements are along with dictation notes. No further information was provided regarding dictation notes with wound measurements.

-July 29, 2022, home care agency wound care dressing instruction sheet - left thigh and lower leg, left posterior thigh, sutured area left lateral leg. wash wound with wound cleanser. Apply skin prep around wound. Cover with bordered foam. Secure dressing with: ace wrap to bilateral thigh, short stretch wrap to lower legs, tubigrip lower leg under short stretch wraps. Sutured area and posterior thigh use 6 x 6 bordered foam. Change dressing M-W-F.

-August 25, 2022, wound clinic note - right posterior thigh length 0.5 cm, width 0.5 cm, depth 0.1 cm; abdomen-mid length 0.2 cm, width 0.2 cm, depth 0.2 cm; lower abdomen-blood blister length 1.0 cm, width 1.0 cm, depth 1.0 cm; left posterior leg length 3.0 cm, width 1.5 cm, depth 0.4 cm

-August 29, 2022, Progress Note wound care - seen August 25, 2022, at wound clinic for recheck of bilateral legs and posterior pressure ulcer on thigh. Home care agency assisting with dressing changes. The surrounding skin of wounds was noted to have erythema, but no increased warmth, no tenderness, no fluctuance, no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 67	01620		

induration, no tape stripping and no rash. Blood blister on lower abdomen, will continue to dress with bordered foam for one more week then discontinue. Lower left abdomen is healed. Dress with bordered foam items one more week then discontinue. Mid abdominal wound over umbilical hernia is new today, small and has no signs of infection. Dress with Triad and cover with bordered foam. Change three times weekly and PRN. Left posterior calf wound: decreased in size. Erythema noted, no warmth. Apply Triad and cover with bordered foam, changing three times weekly. Right posterior thigh ulcer: improved, almost closed. Stage 3 pressure on posterior thigh. Continue to cover with bordered foam, changing three times weekly. Venous insufficiency/lymphedema: ongoing compression and elevation. Today we applied short stretch wraps over tubigrip. Cleanse wound with saline. Apply Triad. Then secondary dressing is foam border. Apply the following items in the morning and take off in the evening comprilan and tubigrip. Change dressings twice a week and as needed.

-August 31, 2022, hospital discharge summary indicated date of admission was August 26, 2022. Skin ulcer of sacrum apply Mepilex 9.2 x 9.2 foam border bandage once every other day.

-September 30, 2022, Progress Note returned from another facility. Primarily diagnosed with debility. Still has ulcers on bilateral buttocks near sacrum measuring 1 centimeter (cm) on the left and 0.5 cm on right. Has ulcers on bilateral legs, right measures 2.5 by 2 cm, left leg measures 4 cm x 4 millimeters (mm). The laceration right knee measured 5 cm x 5 mm at discharge. A home care agency (different than prior home care agency) will be coming in to change dressings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 68 Med changes noted included "acetic acid". -October 2, 2022, Homecare agency skilled nursing note indicated for wounds: left upper buttock pressure ulcer stage 3 - length 1.0 cm, width 0.7 cm; right upper buttock pressure ulcer stage 3 - length 0.1 cm, width 0.3 cm; umbilical - length 0.4 cm, width 0.4 cm; below left knee trauma - length 0.4 cm, width 3.0 cm; left upper calf - skin tear - length 0.2 cm, width 0.3 cm; right lateral foot - length 1.5 cm, width 2.0 cm. -October 4, 2022, Clinic note (primary physician) Last admitted to hospital September 9, 2022, and discharged back to facility September 30, 2022. Chronic lower extremity lymphedema, chronic mixed etiology wounds including coccyx, buttocks, posterior thighs and extremity rooms followed by wound clinic. Wound care at the time of discharge are as follows: bilateral lower extremity cellulitis, resolved; sacral ulcers stage 2 - 2 ulcers on opposing buttocks near sacrum, rinsed with acetic acid and cover with Mepilex. At discharge measured 1 cm on left and 1/2 cm on right; right lower extremity posterior ulcer - wash with acetic acid and cover with Mepilex. At time of discharge measured "2 and half by 2 cm"; left lower extremity posterior ulcer - washed acetic acid and covered with Mepilex. Measured 4 cm x 4 cm at time of discharge. Left lower extremity anterior laceration above the knee, Mastisol placed around wound followed by Steri-strips, covered with Adaptic and ABD pad. Measured 5 cm x 5 cm at time of discharge. -October 11, 2022, Homecare agency skilled nursing note indicated for wounds: left upper buttock pressure ulcer stage 3 - length 1.0 cm, width 0.7 cm; right upper buttock pressure ulcer stage 3 - length 0.8 cm, width 0.5 cm; umbilical -	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 69	01620		

length 0.5 cm, width 0.4 cm; below left knee trauma - length 0.2 cm, width 2.3 cm; left upper calf - skin tear - length 0.3 cm, width 0.4 cm; right lateral foot - not measured; left lateral foot - length 0.8 cm, width 0.9 cm.
-October 11, 2022, Wound Care Dressing Instruction Sheet (home care agency note) indicated right buttock and sacrum - "Triad", change twice weekly and PRN.
-October 11, 2022, Wound Care Dressing Instruction Sheet (home care agency note) indicated left leg - left posterior calf - bordered foam - when leg healed discontinue Kerlix and short stretch wraps and use her own Jobst knee high, discontinue other bordered foam dressings on legs and left foot. Right lateral foot ulcer pressure related, now healed. Protect with Mepilex for one more week then discontinue.
-October 11, 2022, Department of Surgery, Wound and Ostomy Care note indicated bilateral leg and buttock wounds. here for recheck. Resides at assisted living and home care is assisting with dressings. Currently on antibiotic after presenting to ER over the weekend with symptoms of cellulitis. She is wearing short stretch wraps to legs today. She has Velcro wraps and Jobst stockings for lower legs but has not been using them. Longstanding lymphedema bilaterally. Wound Care measurements: right buttock - length 1.0 cm, width 1.0 cm, depth 0.1 cm; coccyx - length 1.0 cm, width 1.0 cm, depth 0.1 cm; coccyx - length 1.0 cm, width 0.5 cm, depth 0.4 cm; left posterior leg - length 0.5 cm, width 0.3 cm, depth 0.2 cm.

-October 14, 2022, Progress Note seen on routine rounds by nurse practitioner. Schedule appointment for wound clinic. Mepilex change every three days per home care request - all orders will come from wound care (wound clinic).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 70 -October 14, 2022, Homecare agency skilled nursing note indicated for wounds: left upper buttock pressure ulcer stage 3 - not measured; right upper buttock pressure ulcer stage 3 - measure weekly (no measurements documented); umbilical - not measured; below left knee trauma - not addressed; left upper calf - skin tear - not measured; right lateral foot - not measured; left lateral foot - not measured R1's MAR dated October 2022, included "acetic acid 0.25% irrig [irrigation] soln [solution] use to irrigate the affected area once daily *open bottle good for 24 HRS* [hours]; dressing change with ABD to bilateral legs 2 times a day wash affected area with mild soap and dry, apply prescribed dressing to ulcer area". R1's Service Checkoff List dated October 2022, indicated "bathing assist of one Monday a.m. RA [resident assistant] will assist resident in and out of shower. Offer to apply lotion to resident's skin. RA will observe skin when assisting with bathing, report any concern (open, rash, redness, swelling) to the nurse. Dressing: assist of one. RA will observe for skin problems and changes in mobility or pain status when providing assistance with dressing, report any changes to the nurse. Skin Care: resident assistant to apply lotion to lower extremities. Resident receives wound care 8 a.m. and 8 p.m. See TAR [treatment administration record] for instructions. The resident assistant will verbally report any changes to the skin such as open areas, drainage or redness to the nurse." R1's record lacked documented evidence of comprehensive assessment of pressure ulcers/wounds upon admission and with changes in skin for pressure areas/wounds, including	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 71	01620		

consistent weekly assessment of pressure ulcers/wounds to include size, appearance, odor, drainage and pain.

On October 19, 2022, at 1:29 p.m. RN-C informed she started working for the licensee on August 2, 2022. RN-C stated she had no prior assisted living experience. RN-C stated, "I am learning it." RN-C stated, "I have not done anything with [R1's] wounds".

On October 21, 2022, at 11:30 a.m. RN-C stated all the information she had for wounds was the information provided to the surveyor. RN-C verified the comprehensive assessment dated June 29, 2022, lacked documented evidence of comprehensive assessment for wounds present upon admission June 29, 2022. RN-C informed R1 had a home care agency providing wound care after admission. When R1 was readmitted on September 30, 2022, a different home care agency started providing wound care. RN-C stated she had no further documented information from the home care agencies than what was provided (as noted above).

14 DAY/90 DAY/CHANGE IN CONDITION ASSESSMENTS
R1's record lacked comprehensive reassessment and monitoring by the RN no more than 14 calendar days after initiation of services, assessment not exceeding 90 calendar days from the last date of the assessment and for change in condition related to ER visits, readmission from hospital and falls.

R1's record indicated assessments by the RN were completed as follows:
-June 29, 2022, VPC assessment Admission or Pre-Move In, Elopement assessment, Fall Risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 72 assessment, Individual Abuse Prevention Plan, Medication Management Assessment, MN Current Resident Roster State Evaluations and Bedrail Assessment. -July 26, 2022, Bedrail Assessment R1's record included the following information: -July 25, 2022, progress note emergency room (ER) visit - seen for leg pain. Imaging from upper chest/neck all the way to feet to evaluate vascular pathology due to spontaneous rupture and subsequent chest pain. Has small hematoma in her leg and foot that will eventually resolve on own. Benefit to wrap leg. Ice area for 20 minutes 2-3 times a day for the first few days. Can also use heat. Leave heat on 20-30 minutes at a time. Make sure to place towel between your leg and heat source. Elevate affected area greater than the level of your heart while laying or sitting down. -August 25, 2022, 5:15 p.m. Resident Incident Report - resident was being transported via EZ stand per LPN's [license practical nurse] instructions. Once staff started to try to move resident, slipped and got cut on left knee. When EMT's [emergency medical technician] arrived had us transfer her again and she passed out and fell to the ground. Resident sent to ER via ambulance. -August 31, 2022, hospital discharge summary indicated date of admission was August 26, 2022. Principle diagnosis causing admission: confusion and UTI. The summary further indicated patient had a right humerus fracture, which was evaluated by orthopedics who recommended sling placement only. In addition, patient had a laceration on left knee which was treated with Steri-strips for skin edge approximation. -September 30, 2022, progress note returned from another facility. Primarily diagnosed with debility.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 73 -October 6, 2022, progress note Orders received to discontinue Augmentin (antibiotic) and start cefdinir (antibiotic) and metronidazole (antibiotic) twice daily for seven days. -October 7, 2022, ER visit note dehydration, weakness general and failure renal acute. Medications given D5W (intravenous sugar) and NaCL (sodium chloride) 0.9% infusion 500 ml and NaCl 0.9% bolus 1,000 ml. -October 14, 2022, ER visit note - urinary tract infection, cefdinir (antibiotic). Medications given Nalco 0.9% bolus 1,000 ml. On October 18, 2022, at 8:43 a.m. R1 stated she had a fall at the facility about six weeks ago which caused "right broken shoulder". R1's record lacked evidence of comprehensive reassessment and monitoring by a RN conducted no more than 14 calendar days after initiation of services as required, ongoing monitoring and reassessment not to exceed 90 calendar days from the last date of the assessment and with change in condition related to ER visits, falls, following hospitalization and readmission form another facility. On October 21, 2022, at 11:30 a.m. RN-C confirmed the above noted assessments were all the assessments completed in R1's record prior to October 17, 2022 (survey start date). RN-C stated, "No I did not" complete a comprehensive assessment for R1 upon return to the facility on September 30, 2022, or for the above noted changes in condition. RN-C stated R1 had another fall on August 31, 2022, at 4:58 p.m. and she had come into the facility and checked R1, and she was ok. RN-C stated we don't have a report for that fall. RN-C stated the fall R1 had on August 25, 2022, "might have been when [R1]	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 74 broke clavicle". R2 R2's record lacked comprehensive reassessment and monitoring by the RN no more than 14 calendar days after initiation of services and for change in condition related to ER visits, readmission from hospital and falls. R2's start of care date for services was July 28, 2022. R2's diagnoses included ureteroileal conduit, Spina bifida with hydrocephalus, mobility impaired. R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including 90 day assessment, annual assessment, COVID-19 monitoring, bathing assist, pendant check, meals, ostomy, compression stocking assist, dressing assist, garbage removal, housekeeping, laundry delivery/wash/pick up, apply topical ointment, medication management/administration, bed mobility occasional assist, incontinence care/toileting assist and colostomy assistance. R2's record lacked a finalized current written service plan upon start of care. On October 18, 2022, at 8:08 a.m. ULP-G, ULP-I and ULP-D were observed to provide nephrostomy tube site cares, assist R2 with hygiene/dressing and transfer R2 using sling and Hoyer lift. At 9:02 a.m., ULP-H was observed to administer medications to R2. R2's record indicated assessments by the RN were completed as follows: -July 28, 2022, VPC Assessment admission or pre-move in and Individual Abuse Prevention	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 75 Plan; and -July 29, 2022, Medication Management Assessment R2's record included the following information: -August 3, 2022, Initial Record of Incident 10:15 a.m. fall bedroom. Self-transferring from wheelchair to bed and fell between them. No injuries. Incident Investigation: fall reduction interventions implemented: wellness checks increased. Comments: resident was made aware he should use pendent when he wants to transfer instead of doing it on his own. -September 9, 2022, Initial Record of Incident 7:00 a.m. fall bedroom. Was trying to get out of bed. Wheelchair was faced the wrong way and when trying to move into it he missed the chair and went onto the floor. No injury. Incident Investigation: fall reduction interventions implemented: pendant or other device within easy reach, wellness checks increased. Comments: resident reminded to use his pendent instead of trying to self-transfer. -September 10, 2022, Initial Record of Incident 7:15 a.m. fall bedroom. Resident states he slipped out of bed because of the railing being up which he says should be down at all times so he can slide into his chair. No injury. Incident Investigation: fall reduction interventions implemented: pendant or other device within easy reach, wellness checks increased. Comments: resident reminded to call before transferring. He just had a fall yesterday, attempting to self-transfer. -September 20, 2022, hospital After Visit Summary indicated dates September 14, 2022, to September 20, 2022, and diagnosis infection urinary tract. Since September 15, 2022, interval placement of bilateral percutaneous nephrostomy tubes. Nephrostomy tubes to be kept to gravity;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 76	01620		

cleanse around tube sites every other day with soap and water, dry well and place split gauze around the tube insertion site, cover with dry gauze. change every other day or sooner if soilage of the gauze is noted. Urostomy - go back to usual pouches, skin care and pouch changes. Intertrigo of groin continue washing with acetic acid 0.25%, dry and apply miconazole 2% powder two times daily. Left toe wounds keep clean and dry. Wear offloading boots as needed for protection.
-September 20, 2022, progress note - hospital return - returned to facility today. New orders for cefepime (antibiotic) and sodium which are infused by Homecare agency twice a day, amoxicillin (antibiotic) order, continue washing groin with acetic acid and apply Miconazole powder twice a day.
-September 24 and 25, 2022, ER After Visit Summary indicated reason for visit shortness of breath and final diagnoses of change in mental status, infection urinary tract and stone ureteral-infected.
-September 26, 2022, progress note indicated resident seen in the ER and mentioned the above diagnoses per ER visit above.

R2's record lacked evidence of comprehensive reassessment and monitoring by a RN conducted no more than 14 calendar days after initiation of services as required, ongoing monitoring and reassessment for change in condition related to ER visits, falls, following hospitalization and readmission form another facility.

On October 21, 2022, at 12:48 p.m. RN-C confirmed the above noted assessments were all the assessments completed in R2's record. RN-C stated a 14-day assessment was not completed for R2 or with changes in condition related to ER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 77	01620		

visits and return from hospitalization as noted above. RN-C stated, "I have not as of yet" completed assessment of residents after falls. RN-C stated, "Some I do, if I am here during the day. RN-C stated if she was out of the building at time of the fall she would check in with the resident when she was back in the building. RN-C verified R1 does not remember things. RN-C stated for the fall on August 3 she had "talked to [staff person] wheelchair needing to be certain way" for resident. RN-C stated she was not in the building at the times R2's falls occurred. RN-C verified there was no documentation of physical assessment by the nurse after the falls. RN-C verified with R2 not being able to remember things, giving reminders to ask for help with transfer may not be effective as an intervention. RN-C confirmed R2 had no finalized service plan, she had printed the service plan agreement and did not review the service plan prior to obtaining R2's signature on October 18, 2022.

R3
R3's record lacked comprehensive reassessment and monitoring by the RN no more than 14 calendar days after initiation of services and for change in condition related to ER visits. In addition, R3's record lacked documented evidence for self-administration of medications.

R3's start of care date for services was May 10, 2022.

R3's diagnoses included acute and chronic respiratory failure with hypoxia, congestive heart failure, abnormal glucose, anxiety, depression, dyspnea, hypoxemia requiring supplemental oxygen.

R3's Service Plan Agreement dated August 2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 78 2022, included meals, temperature, oximeter reading, housekeeping and laundry delivery/wash/pick up. On October 18, 2022, at 9:49 a.m. ULP-J was observed to administer medications to R3. At 10:10 a.m. during interview with R3, medications were observed to be in R3's apartment in the living room area. The medications were albuterol/Ventolin inhalers (provides relief for breathing difficulties), Breo inhaler (provides relief for breathing difficulties), Desenex powder (used to treat skin infections), aspercreme liquid (used for pain), Biofreeze (used for pain), Nicoderm 14 milligram (mg) patches (helps quit smoking) and diclofenac sodium 1% gel (used for pain). During the time of the interview an oxygen concentrator was observed in the living room area set at 1.5 liters and was running. However, the nasal cannula tubing was lying on the carpet in the living room. R3's record indicated assessments by the RN were completed as follows: -May 10, 2022, VPC Assessment admission or pre-move in, Individual Abuse Prevention Plan and Fall Risk Assessment; -July 29, 2022, Medication Management Assessment indicated "not applicable, plan already in place for staff to administer medications" for self-administer medications. -August 3, 2022, VPC Assessment 90 day, Fall Risk Assessment, and Medication Management Assessment indicated "not applicable, plan already in place for staff to administer medications" for self-administer medications. R3's record included the following information: -July 26, 2022, ER After Visit Summary indicated chronic obstructive pulmonary disease	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 79 exacerbation. -July 27, 2022, progress note indicated resident was seen yesterday in the ER for shortness of breath and returned on July 26, 2022. Recommended increase Lasix (used to reduce fluid in body) to two times daily for three days. R3's record lacked evidence of comprehensive reassessment and monitoring by a RN conducted no more than 14 calendar days after initiation of services as required, monitoring and reassessment for change in condition related to ER visit and assessment of self-administration of medications. On October 21, 2022, at 1:19 p.m. RN-C confirmed the above noted assessments were all the assessments completed in R3's record. RN-C stated a 14-day assessment was not completed for R3 or with change in condition related to ER visit. RN-C stated R3 did not have a self-administration of medications assessment completed to indicate if R3 was able to safely self-administer the medications in his apartment safely. R7 R7's record lacked comprehensive reassessment and monitoring by the RN for a change in condition related to falls and a change in physical status. R7's start of care date for services was June 1, 2022, and had diagnoses including mild intellectual disabilities. R7's record lacked a finalized Service Plan Agreement prior to the start of survey on October 17, 2022. A Service Plan agreement was provided (after the surveyor requested it) dated	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 80 October 19, 2022. The service plan agreement indicated R7 received services including 90 day assessment, annual assessment, COVID-19 monitoring, therapeutic exercise/movement, activity reminder, bathroom cleaning, meals, vital signs, weight, bed making, housekeeping, laundry, medication management/administration and daily check. R7's record identified R7 had 13 falls between the dates of June 1, 2022, and October 17, 2022. R7's Progress Notes/Resident Incident Reports/Incident Investigation identified injuries were sustained, emergency room (ER) visits or hospitalization occurred related to falls for the following dates: -June 12, 2022, hit head -June 17, 2022, complaints of pain left knee. -July 13, 2022, Progress Note seen in ER last night after a fall. -July 31, 2022, pain right arm/hand -August 1, 2022, bruise right knee -September 14, 2022, pain where she hit head on right side, back of head. Medical Care: yes. ER does not want any more visits from resident per (guardian). -September 16, 2022, pain right shoulder The incident reports dated from June 15, 2022, through August 1, 2022 (10 total) identified for "fall reduction interventions implemented" the following was repeated for documentation of interventions implemented related to falls: pendent or other device within easy reach, placement - articles of need within easy reach, positioning - resident mobility patterns reviewed (one time), pendent or other devices within easy reach, placement -articles of need within easy reach (two times), pendent or other devices within	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 81	01620		

easy reach, pain assessed, placement -articles of need within easy reach (six times) and one incident report had no documented investigation/intervention implemented. Dated September 14, 2022, through September 27, 2022 (three total) signed by RN-C, indicated "pendent or other device within easy reach" for intervention implemented.

R7's record lacked evidence the RN had conducted comprehensive assessment of the resident for a change in condition related to falls, including implementation of interventions from review of causative factors to minimize the risk for future falls and potential injury.

R7's Progress Notes/Resident Incident Reports/Incident Investigation identified changes in status for the following dates:
-June 23, 2022, Progress Note was sent to ER last night by staff. Resident complaining of leg pain, swelling and legs are warm to touch. Seen in ER and discharge back to facility this morning with a new order for Lasix 20 mg daily for 10 days.
-July 24, 2022, Resident Incident Report at 10:26 p.m. found lying in bed shaking uncontrollably and not responding. Resident sent to ER for evaluation.
-July 25, 2022, Progress Note seen in ER last night after being found lying in bed shaking and non-responsive for about 15 minutes. Resident diagnosed with general headache without cause.
-August 18, 2022, Progress note sent to ER on the evening of August 14, 202 for suicidal intentions and self injury behavior. Subsequently admitted to psychiatric services unit for safety and stabilization. Medications were changed. At the time of her discharge today symptoms had improved adequately. Suicidal ideation reduced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 82 with increased confidence in self managing risk. Anxiety improved with increased confidence in ability to manage symptoms. R7's record indicated assessments by the RN were completed as follows: -June 1, 2022, VPC Assessment admission or pre-move in -August 25, 2022, VPC Assessment 90 day -August 25, 2022, Fall Risk Assessment -August 25, 2022, Medication Management Assessment -August 25, 2022, MN Current Resident Roster State Evaluations R7's record lacked evidence the RN had conducted comprehensive assessment of the resident for a change in condition related to falls, including implementation of interventions from review of causative factors to minimize the risk for future falls and potential injury and lacked documented evidence of comprehensive assessment by the RN for changes in condition related to ER visits and readmission following hospitalization. On October 21, 2022, at 1:44 p.m. RN-C stated, "I can only speak to the time I have been here" regarding falls for R7. RN-C verified the documented implemented interventions remained consistently the same for R7. RN-C verified assessments completed for R7 since start of care were as noted above. RN-C stated R7 was currently receiving therapy and the therapy was "going well". RN-C stated we try to redirect R7 for behaviors. RN-C stated R7's guardian and informed R7 if she had any more falls, she would be moved out of the facility. RN-C stated she had checked R7 after the falls but had not documented any information in R7's record.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 83 R4 R4's record lacked comprehensive reassessment and monitoring by the RN no more than 14 calendar days after initiation of services, every 90 days and for change in condition related to ER visit/hospitalization. R4's record lacked follow up assessment after a known fall. R4's diagnoses included type 2 diabetes (when a person's pancreas cannot create sufficient insulin to manage blood sugar), history of falls, anxiety, depression, and chronic kidney disease. R4's record indicated R4 started receiving assisted living services from the licensee on January 31, 2022. R4's service plan dated July 29, 2022, indicated R4 received services to include medication administration, covid-19 monitoring, toileting and dressing assistance, bed mobility and ambulation assist of one staff, housekeeping, laundry, and staff escort to destinations in the facility. On October 18, 2022, at approximately 8:00 a.m. unlicensed personnel (ULP)-E was observed to provide a blood sugar check, oral medications, and insulin injection to R4. R4's record indicated assessments by the RN were completed as follows: -January 31, 2022, VPC Assessment-Admission -January 31, 2022, Fall Risk Assessment -February 21, 2022, VPC Assessment-14 day -June 16, 2022, VPC 90 day Assessment -June 16, 2022, Fall Risk Assessment -June 21, 2022, Medication Management Assessment -October 3, 2022, VPC 90 day Assessment	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 84 R4's record included the following information: -R4's Progress note dated May 20, 2022, read "RETURN- Resident was sent into the ED (emergency department) via ambulance on May 12, 2022, by staff. She (R4) was very confused, not at baseline and shaking uncontrollably. Resident was then air lifter to Rochester, Saint Mary's Campus. Dx (diagnosis) was sepsis due to E. Coli (escherichia coli). Resident was treated with Bactrim DS. The following medications were changed; Tylenol, allopurinol, insulins, lisinopril, and omeprazole. Discharge paperwork was sent to pharmacy, and resident provider. Resident is scheduled for post hospital visit on Monday May 30, 2022, at 1:30 p.m." -Fall incident report dated September 25, 2022, indicated a fall from a blanket that was wrapped around R4. Resident follow up and prevention read "Service plan interventions were followed and/or in place at time of fall." R4's record lacked evidence of comprehensive reassessment and monitoring by a RN conducted no more than 14 calendar days after initiation of services as required and monitoring and reassessment for change in condition related to ER visit, falls, and every 90 days. On October 18, 2022, at 3:00 p.m. RN-C confirmed all assessments completed for R4 were provided, and verified no change in condition assessment was completed following R4's hospitalization in May 2022. RN-C stated she could only speak to the time period since she started in August 2022. RN-C stated she was still learning her responsibilities and timelines for the required assessments and would work on creating a tracking mechanism for due dates for assessments. RN-C verified there was no	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 85 documentation of physical assessment by the nurse after the fall on September 25, 2022. R5 R5's record lacked comprehensive reassessment and monitoring by the RN every 90 days and with change in condition (development of coccyx wound). In addition, R5's record lacked documented weekly wound measurements. R5's diagnoses included lupus anticoagulation syndrome (an autoimmune disorder that causes blood clots to form in various parts of the body), thrombosis (blood clot) of deep veins of unspecified lower extremity and history of pulmonary embolism (blood clot in the lung) with long term anticoagulation (blood thinning) management, glaucoma, heart murmur, high blood pressure, pulmonary fibrosis (condition where the lung tissue becomes damaged or scarred) and memory loss. R5's service plan dated August 11, 2022, indicated R5 received services to include medication administration, dressing assist of one, TED (thromboembolism deterrent) assistance, wound care, denture assistance, COVID-19 monitoring, meals, laundry, and housekeeping. R5's Medication Administration Record (MAR) dated October 2022, included treatment of intragluteal wound that read Meiplex border flex, apply to reddened area on each intergluteal fold every three days. On October 18, 2022, at approximately 8:45 a.m. unlicensed personnel (ULP)-E was observed to check R5's coccyx wound. No dressing was observed on wound. ULP E stated she had not applied the dressing since she worked last due to	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 86 the wound appearing better. ULP-E stated she had left a message for the nurse about the noted improvement. R5's record indicated assessments by the RN were completed as follows: -December 27, 2021, VPC Assessment 90 day -December 27, 2021, Medication Self Administration -December 27, 2021, Individualized Abuse Prevention Plan -April 5, 2022, VPC Assessment 90 day -May 27, 2022, VPC Assessment Change in condition for gluteal wound-the assessment indicated Physical Therapy (PT) initiated March 2022 for gluteal wound. -May 27, 2022, Medication Management Assessment -September 7, 2022, VPC Assessment 90 day-incomplete assessment with missing content to include skin/wound assessment information. R5's record included the following information: -April 1, 2022, Therapy note R5 was seen on March 31, 2022, Did see one day for strengthening and balance. -April 6, 2022, Therapy note-(R5) seen on March 29, 2022, by Occupational Therapy (OT). Gave daughter information on types of pressure relief cushions for recliner. -April 8, 2022, Therapy note-R5 was seen yesterday by PT. She was seen twice this week to work on strengthening, fall prevention and over all endurance. Reminders to avoid getting tangled in blanket in recliner. -April 11, 2022, Therapy note- R5 was seen on April 5, 2022, gave daughter information on types of pressure relief cushions for recliner. -April 15, 2022, Therapy note-Resident was seen on April 14, 2022, Worked on ambulation from the	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 87	01620		

living room to the front porch door. Advise it would be best to have someone with her for fall prevention.
-April 19, 2022, Bluestone note-Resident was seen today on routine rounds. No new orders.
-April 20, 2022, Therapy note-Resident was seen on April 11, 2022 by OT. Plan to order swivel slide shower chair and a cushion for her recliner.
-April 27, 2022, Therapy note- R5's daughter declined option of the shower chair. R5 loves the pressure relief cushion.
-May 17, 2022, Bluestone note-Resident was seen by provider for routine visit. No new orders.
-June 23, 2022, Bluestone note-Resident was seen on June 21, 2022, by provider on routine rounds. Skilled nursing ordered to evaluate and treat resident's wound.
-July 21, 2022 Bluestone note-Resident was seen by provider for routine visit. No new orders/changes.
-August 16, 2022 Bluestone note-Resident seen today on routine rounds by provider. labs ordered.
-September 15, 2022, INR-results
-September 20, 2022, Provider note-(R5) has had stage one pressure ulcer on both intergluteal folds. Staff is changing her Mepilex every three days and family is monitoring her sores.
-September 21, 2022 Provider note-Resident was seen by provider. No new orders
-September 27, 2022 Provider communication with daughter/facility-will DC (discontinue) the Mepilex.
-October 6, 2022 INR results

Wound documentation
R5's record lacked description of coccyx wound including weekly measurements.

On October 19, 2022, at 3:00 p.m. RN-C stated that since she started working in August she "had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 88	01620		

little contact with R5 and had not looked at her (R5's) wound." RN-C verified R5's record lacked documentation of R5's wound to include description, measurements and changes. RN-C stated she could only speak to the time period since August when she started employment and confirmed the surveyor had all assessment information to date. RN-C stated she had just figured out the assessment she completed on September 7, 2022, had incomplete information as she "apparently had not saved her work but had electronically signed it." RN-C was unable to recover the contents of the assessment.

The licensee's Initial and On-Going Nursing Assessment of Residents Under the Assisted Living License policy dated July 21, 2021, indicated a RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required for pre-admission assessment, 14 day assessment, ongoing assessment completed periodically but no less than every 90 days and for change in condition. A RN would complete assessments as indicated by individual resident circumstances. A comprehensive assessment included but may not be limited to the requirements outlined by Minnesota rules. The RN would reassess the resident if the resident had a change in condition.

The licensee's Falls Prevention and Reduction policy dated August 1, 2021, indicated the RN would incorporate any interventions to prevent or reduce falls into the residents service plan. When a resident experiences a fall the director of health services or designee would review the fall in an attempt to determine the root cause analysis, every fall would be reviewed and the review was to be documented in the electronic record. Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01620	Continued From page 89 review notes are completed int he resident's electronic health record. Notes are made after the fall occurred, summarizing information gathered at the time of the fall and the resident's current status as it relates to the effects or potential effects of the fall and determining root cause analysis and when necessary document evaluation of interventions trialed and unsuccessful and the implementation of new intervention(s) after unsuccessful trial. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	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. (c) The facility must implement and provide all 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.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 90 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days for three of three residents (R1, R2, R3) and failed to ensure revision of the service plan with changes in services for four of four residents (R1, R2, R3, R4). 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: R1 R1's record lacked a finalized service plan no later than 14 calendar days after the date services were first provided and lacked evidence of revision of the service plan with change in services. R1's start of care date for services was June 29, 2022. R1's diagnoses included Type 2 diabetes mellitus with other circulatory complications, cellulitis of right and left lower limb, acute kidney failure,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 91 morbid (severe) obesity and lymphedema. R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including annual assessment, 90 day assessment, bathing every Monday, meals (breakfast, noon, supper) every day, dressing (a.m. and p.m.) every day, skin care (the resident assistant will verbally report any changes to the skin such as open areas, drainage or redness to the nurse. The nurse will review the results at least every 90 days to update the prescriber as indicated) a.m. every day, bed making a.m. every day, garbage removal p.m. every day, housekeeping a.m. every Tuesday, linen change a.m. every second Sunday, laundry delivery a.m. every Tuesday, laundry wash a.m. every Tuesday, laundry pick up a.m. every Tuesday, medication management and administration (a.m. and p.m. every day) and incontinence care/toileting (a.m. and p.m.) every day. R1's record lacked a finalized service plan no more than 14 days after the date that services were first provided on June 29, 2022. On October 18, 2022, at 8:43 a.m. R1 stated the licensee's staff provided wound cares, toileting, transfers, blood sugar checks, giving medications and housekeeping. R1 stated a "wound nurse" also comes to the facility "two times a week on Monday and Friday" to provide "wound cares." R1 stated she had "cellulitis" in both legs, and she had two open areas on right leg and one open area on left leg. R1 stated she had "one big and one small joined" wound on bottom. On October 19, 2022, at 8:43 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and provide wound dressing changes to R1's left and right lower extremities, umbilical area, coccyx area and right and left buttocks.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 92 ULP-D removed ace wrap (long stretch bandages used for compression) from both of R1's lower legs/feet. On October 20, 2022, at 1:08 p.m. ULP-D stated, "Yes [R1] uses a CPAP" (continuous positive airway pressure medical device). ULP-D provided a prescriber's order for R1's CPAP which she stated expired yesterday. R1's Medication Administration Record (MAR) dated October 2022, identified staff administered medications to R1 and included "acetic acid 0.25% irrig [irrigation] soln [solution] use to irrigate the affected area once daily *open bottle good for 24 HRS* [hours]; dressing change with ABD [abdominal absorbent pad] to bilateral legs 2 times a day, wash affected area with mild soap and dry, apply prescribed dressing to ulcer area" and blood glucose monitoring four times a day. R1's Service Checkoff List dated October 2022, identified the staff documented the above services as noted above on R1's Service Plan Agreement. In addition, the list identified staff documented blood sugar checks four times a day. R1's Department of Surgery, Wound, and Ostomy Care note dated October 11, 2022, indicated short stretch wraps (low elasticity bandages which allows for about 60 percent extensibility of its original length), were to be applied bilaterally on lower legs, the resident has Velcro compression garments (wraps used for compression) and Jobst stockings (used to reduce swelling caused by fluid) to wear (ok to transition anytime) and included wound dressing change orders for areas of lateral foot ulcers, left posterior calf ulcer, right posterior thigh/ishial	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 93 (lower part of the hip area) ulcer and right buttock/coccyx (the very bottom portion of the spine area) ulcers. R1's Service Plan Agreement lacked revision to include the services of assisting with transfers and treatment services for wound dressing changes, blood sugar checks, CPAP assist, Ace wraps, short stretch wraps, Velcro compression garments and Jobst stockings. On October 21, 2022, at 11:30 a.m. registered nurse (RN)-C verified R1's service plan was dated August 8, 2022. RN-C reviewed R1's service plan and verified the service plan lacked revision for services being provided as noted above. RN-C stated the staff were assisting with R1's CPAP. R2 R2's record lacked a finalized service plan no later than 14 calendar days after the date services were first provided and lacked evidence of revision of the service plan with change in services. R2's start of care date for services was July 28, 2022. R2's diagnoses included ureteroileal conduit, spina bifida with hydrocephalus, mobility impaired. R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including 90 day assessment, annual assessment, COVID-19 monitoring a.m. every day, bathing assist p.m. every Tuesday and Friday, pendant check a.m. and p.m. every day, meals (breakfast, noon, supper) every day, ostomy a.m., p.m., night every	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 94	01640		

day and as needed (PRN), compression stocking a.m. every day, dressing a.m. and p.m. every day, garbage removal a.m. and p.m. every day, housekeeping a.m. every Friday, laundry delivery a.m. every Friday, laundry wash a.m. every Friday, laundry pick up a.m. every Friday, apply topical ointment PRN, medication management/administration a.m. and p.m. every day, bed mobility a.m., p.m. and night every day, incontinence care/toileting a.m., p.m. and night every day and colostomy a.m. every day and PRN. R2's record lacked a finalized service plan no more than 14 days after the date that services were first provided on July 28, 2022.

On October 18, 2022, at 8:08 a.m. ULP-G, ULP-I and ULP-D were observed to provide nephrostomy tube (a plastic tube passed from the back, through the skin and kidney to the point where urine collects) site care (right and left sides), empty drainage bag for nephrostomy sites, empty drainage bag for urostomy observed to be located on R2's right side abdomen area, assist R2 with hygiene/dressing and transfer R2 using sling and Hoyer lift. At 9:02 a.m., ULP-H was observed to administer medications to R2.

R2's MAR dated October 2022, identified staff administered medications to R2 and included "acetic acid 0.25% irrig soln use twice daily for wound cleansing".

R2's Service Checkoff List dated October 2022, identified the staff were documenting for the above services as noted above on R2's Service Plan Agreement.

R2's Service Plan Agreement lacked revision to include the services of nephrostomy cares, urostomy cares, hygiene and transfers via Hoyer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 95 On October 21, 2022, at 12:48 p.m. RN-C verified R2 did not have a finalized service plan, she had printed the service plan agreement and did not review the service plan prior to obtaining R2's signature on October 18, 2022. RN-C reviewed R2's service plan and verified the service plan lacked revision for services being provided as noted above. RN-C further stated R2 did not have an a colostomy, as was incorrectly listed in the service plan. RN-C stated the staff were providing the service of compression stockings for R2. R3 R3's record lacked a finalized service plan no later than 14 calendar days after the date that services were first provided and lacked evidence of revision of the service plan with change in services. R3's start of care date for services was May 10, 2022. R3's diagnoses included acute and chronic respiratory failure with hypoxia, congestive heart failure, abnormal glucose, anxiety, depression, dyspnea, hypoxemia requiring supplemental oxygen. R3's Service Plan Agreement dated August 2, 2022, indicated services included meals (breakfast, noon, supper) every day, temperature a.m. every day, oximeter reading a.m. every day, housekeeping a.m. every Wednesday, laundry wash a.m. every Wednesday, laundry pick up a.m. every Wednesday and laundry delivery a.m. every Wednesday. R3's record lacked a finalized service plan no more than 14 days after the date that services were first provided on May 10, 2022.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 96 On October 18, 2022, at 9:49 a.m. ULP-J was observed to administer medications to R3. On October 18, 2022, at 10:10 a.m. R3 stated the licensee's staff provided the services of medication administration and cleaned his apartment. R3's MAR dated October 2022, identified staff administered medications to R3. R3's Service Checkoff List dated October 2022, identified the staff documented for the above services as noted above on R3's Service Plan Agreement. R3's Service Plan Agreement lacked revision to include the services of medication administration. On October 21, 2022, at 1:19 p.m. RN-C verified R3's service plan was dated August 2, 2022. RN-C reviewed R3's service plan and verified the service plan lacked revision for the provided service of medication administration. R4 R4 started receiving assisted living services from the licensee on January 31, 2022. R4's diagnoses included type 2 diabetes (when a person's pancreas cannot create sufficient insulin to manage blood sugar), history of falls, anxiety, depression, and chronic kidney disease. R4's service plan dated July 29, 2022, indicated R4 received services including medication administration, COVID-19 monitoring, toileting and dressing assistance, bed mobility and ambulation assist of one staff, housekeeping,	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 97 laundry, and staff escort to destinations in the facility; however, R4's service plan lacked the service of blood sugar checks. On October 18, 2022, at approximately 8:00 a.m. ULP-E was observed to provide a blood sugar check, oral medications, and insulin injection to R4. R4's Medication Administration Record (MAR) dated October 2022, indicated R4 received medications to include, two medications for pain, one for gout, one for depression, two for blood sugar management, two for asthma and shortness of breath, one for gastroesophageal reflux, one for high cholesterol, one for urinary tract infection maintenance/prevention, one for allergies, one for constipation, one for anxiety, and one for sleep. Additionally, the MAR indicated blood sugar monitoring before meals and at bedtime each day. On October 21, 2022, at 11:20 a.m. RN-C verified the service plan lacked the service of blood sugar checks. The licensee's Medication and Treatment-Administration and Delegation policy (7.15) dated August 2021, read the licensee will prepare and include in the Service Plan a written statement of the medication management or treatment/therapy services that would be provided to the resident. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated a finalized service plan would be completed no later than 14 calendar days after initiation of services and would be reviewed and revised as needed based upon on-going resident assessment.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01640	Continued From page 98 No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01650	Continued From page 99 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for four of four residents (R1, R2, R3, R4). 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: R1 R1's diagnoses included Type 2 diabetes mellitus with other circulatory complications, cellulitis of right and left lower limb, acute kidney failure, morbid (severe) obesity and lymphedema. R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including annual assessment, 90 day assessment, bathing every Monday, meals (breakfast, noon, supper) every day, dressing (a.m. and p.m.) every day, skin care (the resident assistant will verbally report any changes to the skin such as open areas, drainage or redness to the nurse. The nurse will review the results at least every 90 days to update the prescriber as indicated) a.m. every day, bed making a.m. every day, garbage removal p.m. every day, housekeeping a.m. every Tuesday, linen change a.m. every second Sunday, laundry delivery a.m. every Tuesday, laundry wash a.m. every Tuesday, laundry pick	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01650	Continued From page 100	01650		

up a.m. every Tuesday, medication management and administration (a.m. and p.m. every day) and incontinence care/toileting (a.m. and p.m.) every day. In addition, the service plan indicated "Advance directives" but did not have any documented information to indicate if R2 had an advance directive or not.

R1's Medication Administration Record (MAR) dated October 2022, identified staff were administering medications to R1 and included "acetic acid 0.25% irrig [irrigation] soln [solution] use to irrigate the affected area once daily *open bottle good for 24 HRS* [hours]; dressing change with ABD [abdominal absorbent pad] to bilateral legs 2 times a day, wash affected area with mild soap and dry, apply prescribed dressing to ulcer area" and blood glucose monitoring four times a day.

R1's Service Checkoff List dated October 2022, identified the staff documented for the above services as noted above on R1's Service Plan Agreement. In addition, the list identified staff were documenting for the services of blood sugar checks four times a day.

R1's Department of Surgery, Wound, and Ostomy Care note dated October 11, 2022, indicated short stretch wraps (low elasticity bandages which allows for about 60 percent extensibility of its original length), were to be applied bilaterally on lower legs, the resident has Velcro compression garments (wraps used for compression) and Jobst stockings (used to reduce swelling caused by fluid) to wear (ok to transition anytime) and included wound dressing change orders for areas of lateral foot ulcers, left posterior calf ulcer, right posterior thigh/ischial (lower part of the hip area) ulcer and right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01650	Continued From page 101 buttock/coccyx (the very bottom portion of the spine area) ulcers. On October 18, 2022, at 8:43 a.m. R1 stated the licensee's staff provided the services of wound cares, toileting, transfers, blood sugar checks, giving medications and housekeeping. R1 stated a "wound nurse" also comes to the facility "two times a week on Monday and Friday" to provide "wound cares." R1 stated she had "cellulitis" in both legs, and she had two open areas on her right leg and one open area on her left leg. R1 stated she had "one big and one small joined" wound on bottom. On October 19, 2022, at 8:43 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and provide wound dressing changes to R1's left and right lower extremities, umbilical area, coccyx area and right and left buttocks. ULP-D removed ace wrap (long stretch bandages used for compression) from both of R1's lower legs/feet. On October 20, 2022, at 1:08 p.m. ULP-D stated, "[R1] uses a CPAP" (continuous positive airway pressure medical device). ULP-D provided a prescriber's order for R1's CPAP, which she stated expired yesterday. R1's Service Plan Agreement lacked the following: -a description of the services to be provided, the fees for services and the frequency of each service (for assisting with transfers, treatment services of for wound dressing changes, blood sugar checks, CPAP assist, Ace wraps, short stretch wraps, Velcro compression garments and Jobst stockings); -the identification of staff or categories of staff	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01650	Continued From page 102 who will provide the services (for the above); -a contingency plan that includes: the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B (living will) On October 21, 2022, at 11:30 a.m. registered nurse (RN)-C verified R1's service plan lacked the above content. R2 R2's diagnoses included ureteroileal conduit, spina bifida with hydrocephalus, mobility impaired. R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including 90 day assessment, annual assessment, COVID-19 monitoring a.m. every day, bathing assist p.m. every Tuesday and Friday, pendant check a.m. and p.m. every day, meals (breakfast, noon, supper) every day, ostomy a.m., p.m., night every day and as needed (PRN), compression stocking a.m. every day, dressing a.m. and p.m. every day, garbage removal a.m. and p.m. every day, housekeeping a.m. every Friday, laundry delivery a.m. every Friday, laundry wash a.m. every Friday, laundry pick up a.m. every Friday, apply topical ointment PRN, medication management/administration a.m. and p.m. every day, bed mobility a.m., p.m. and night every day, incontinence care/toileting a.m., p.m. and night every day and colostomy a.m. every day and PRN. The service plan further indicated "provider" (who provides the service) and "Package" (fee for service) but did not have documented information for the areas for each service listed. On October 18, 2022, at 8:08 a.m. ULP-G, ULP-I and ULP-D were observed to provide	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01650	Continued From page 103 nephrostomy tube (a plastic tube passed from the back, through the skin and kidney to the point where urine collects) site care (right and left sides), empty drainage bag for nephrostomy sites, empty drainage bag for urostomy observed to be located on R2's right side abdomen area, assist R2 with hygiene/dressing and transfer R2 using a sling and Hoyer lift. At 9:02 a.m., ULP-H was observed to administer medications to R2. R2's MAR dated October 2022, identified staff administered medications to R2 and included "acetic acid 0.25% irrig soln twice daily for wound cleansing. R2's Service Checkoff List dated October 2022, included staff documentation for the above services as noted above on R2's Service Plan Agreement. R2's Service Plan Agreement lacked the following: -a description of the services to be provided, the frequency of each service (for nephrostomy cares, urostomy cares, hygiene and transfers via Hoyer) and the fees for services (for all services); and -the identification of staff or categories of staff who will provide the services (for all services) On October 21, 2022, at 12:48 p.m. RN-C verified R2's service plan lacked the above content. R3 R3's diagnoses included acute and chronic respiratory failure with hypoxia, congestive heart failure, abnormal glucose, anxiety, depression, dyspnea, hypoxemia requiring supplemental oxygen.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01650	Continued From page 104 R3's Service Plan Agreement dated August 2, 2022, indicated services included meals (breakfast, noon, supper) every day, temperature a.m. every day, oximeter reading a.m. every day, housekeeping a.m. every Wednesday, laundry wash a.m. every Wednesday, laundry pick up a.m. every Wednesday and laundry delivery a.m. every Wednesday. In addition, the service plan indicated "Advance directives," but did not have any documented information to indicate if R3 had an advance directive or not. On October 18, 2022, at 9:49 a.m. ULP-J was observed to administer medications to R3. On October 18, 2022, at 10:10 a.m. R3 stated the licensee's staff provided the services of medication administration and apartment cleaning. R3's MAR dated October 2022, identified staff administered medications to R3. R3's Service Checkoff List dated October 2022, included staff documentation for the above services as noted above on R3's Service Plan Agreement. R3's Service Plan Agreement lacked the following: -a description of the services to be provided, the fees for services, and the frequency of each service (for medication administration); -the identification of staff or categories of staff who will provide the service (for medication administration); and -a contingency plan that includes: the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B (living will)	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01650	Continued From page 105 On October 21, 2022, at 1:19 p.m. RN-C verified R3's service plan lacked the above content. R4 R4 started receiving assisted living services from the licensee on January 31, 2022. R4's diagnoses included type 2 diabetes (when a person's pancreas cannot create sufficient insulin to manage blood sugar). R4's service plan dated July 29, 2022, indicated R4 received services to include medication administration, COVID-19 monitoring, toileting and dressing assistance, bed mobility and ambulation assist of one staff, housekeeping, laundry, and staff escort to destinations in the facility; however, R4's service plan lacked the service of blood sugar checks. On October 18, 2022, at approximately 8:00 a.m. ULP-E was observed to provide a blood sugar check, oral medications, and insulin injection to R4. R4's Medication Administration Record (MAR) dated October 2022, indicated R4 received blood sugar monitoring before meals and at bedtime each day. R4's record lacked service of blood sugar checks and the required content of that service to include: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; and - the identification of staff or categories of staff who will provide the services	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01650	Continued From page 106 On October 21, 2022, at 11:20 a.m. RN-C verified the service plan lacked the service of blood sugar checks and lacked the required content of the service. The licensee's Medication and treatment-Administration and delegation policy (7.15) dated August 2021, read the licensee will prepare and include in the Service Plan a written statement of the medication management or treatment/therapy services that would be provided to the resident. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated the resident service plans would include the required content according to 144G.70 Subd. 4. (f). No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01650		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 107	01700		

resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure assessment of medication management services included all required content for five of five residents (R1, R2, R3, R4, R5).

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:

R1
R1's diagnoses included Type 2 diabetes mellitus

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 108	01700		

with other circulatory complications, cellulitis of right and left lower limb, acute kidney failure, morbid (severe) obesity and lymphedema.

R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including medication management and administration.

On October 18, 2022, at 8:43 a.m. R1 stated the licensee's staff provided the service of medication administration.

R1's Medication Administration Record (MAR) dated October 2022, indicated staff administered one medication used for increase in bone density, one used for heart prevention, two used to control high blood sugar, two used to help breathing, one used for anxiety, three supplements, one used to treat bacterial infection, one used for depression/anxiety, three used for allergies, two used for constipation, one used to treat low potassium levels, one used to treat underactive thyroid gland, two used for pain, two used to treat high blood pressure, one used for nausea/vomiting, one used to treat infection caused by fungus/yeast, one used to reduce inflammation, one used to treat high cholesterol, one used to treat and prevent ulcers, one used to treat migraine, one to reduce fluid in body, one used to dissolve gallstones, one used for eye allergies, one used for low blood sugar, one used to treat dizziness, one used for chest pain, one used for dry eyes and one used for muscle spasms.

R1's Medication Management Assessment was dated June 29, 2022. The assessment did not reference another document regarding a list of medications reviewed for the assessment. R1's medication assessment did not address the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 109	01700		

following required content:
-identification of all medications the resident is known to be taking;
-identification of indications for medications;
-identification and review of side effects;
-identification and review of contraindications and actions to address these issues

On October 21, 2022, at 11:30 a.m. registered nurse (RN)-C verified R1's medication management assessment lacked the above.

R2
R2's diagnoses included ureteroileal conduit, spina bifida with hydrocephalus, mobility impaired.

R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including medication management/administration.

On October 18, 2022, at 9:02 a.m. ULP-H was observed to administer medications to R2.

R2's MAR dated October 2022, indicated staff were administering six medications to help breathing, two used to treat anxiety, one used to treat seizures, two used to treat high blood pressure, one used to treat Alzheimer's disease, one used to treat infection of skin, one used to treat heartburn, one used to treat high cholesterol, one used for heart prevention, one used for depression, one used for eye allergy and one used for sleep.

R2's Medication Management Assessment was dated July 29, 2022. The assessment did not reference another document regarding a list of medications reviewed for the assessment. R2's medication assessment did not address the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 110 following required content: -identification of all medications the resident is known to be taking; -identification of indications for the medications; -identification of side effects; -identification and review of contraindications and actions to address these issues On October 21, 2022, at 12:48 p.m. RN-C verified R2's medication management assessment lacked the above. R3 R3's diagnoses included acute and chronic respiratory failure with hypoxia, congestive heart failure, abnormal glucose, anxiety, depression, dyspnea, hypoxemia requiring supplemental oxygen. R3's Service Plan Agreement dated August 2, 2022, indicated services included three meals every day, temperature daily, oximeter reading daily, housekeeping weekly, and laundry wash, pick up and deliver weekly. The service plan lacked the service of medication administration. On October 18, 2022, at 9:49 a.m. ULP-J was observed to administer medications to R3. On October 18, 2022, at 10:10 a.m. R3 stated the licensee's staff provided the services of medication administration. During the interview, the following medications were observed in R3's living room: albuterol/Ventolin inhalers (provides relief for breathing difficulties), Breo inhaler (provides relief for breathing difficulties), Desenex powder (used to treat skin infections), aspercreme liquid (used for pain), Biofreeze (used for pain), Nicoderm 14 milligram (mg) patches (helps quit smoking) and diclofenac	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 111 sodium 1% gel (used for pain). R3's MAR dated October 2022, indicated staff administered one medication used for anxiety, two used for supplement, three used to treat high blood pressure, one used to prevent blood clots, one used to treat depression, one used to reduce fluid in the body, one used to treat movements in face/tongue/or other body parts that cannot be controlled, one used to treat low potassium levels, one used to treat multiple myeloma (cancer), one used to treat schizophrenia/bipolar disorder, one used to treat infections, three used to help breathing, one used for virus infections, three used to treat pain, one used to treat diarrhea and one used to treat skin condition (itchy or red irritation). R3's Medication Management Assessment was dated August 3, 2022. The assessment did not reference another document regarding a list of medications reviewed for the assessment. R3's medication assessment did not address the following required content: -identification of all medications the resident is known to be taking; -identification of indications for medications; -identification and review of side effects; -identification and review of contraindications and actions to address these issues On October 21, 2022, at 1:19 p.m. RN-C verified R3's medication management assessment lacked the above. R4 R4's diagnoses included type 2 diabetes (when a person's pancreas cannot create sufficient insulin to manage blood sugar), history of falls, anxiety, depression, and chronic kidney disease.	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 112 R4's service plan dated July 29, 2022, indicated R4 received services including medication administration. R4's MAR dated October 2022, indicated R4 received medications to include, two medications for pain, one for gout, one for depression, two for blood sugar management, two for asthma and shortness of breath, one for gastroesophageal reflux, one for high cholesterol, one for urinary tract infection maintenance/prevention, one for allergies, one for constipation, one for anxiety, and one for sleep. On October 18, 2022, at approximately 8:00 a.m. ULP-E was observed to provide oral medications and insulin injection to R4. R4's medication Management Assessment was dated June 21, 2022. The assessment did not reference another document regarding a list of medications reviewed for the assessment. R4's medication assessment did not address the following required content: -identification of all medications the resident is known to be taking; -identification of indications for medications; -identification and review of side effects; -identification and review of contraindications and actions to address these issues On October 21, 2022, at 10:45 a.m. RN-C verified R4's medication assessment lacked the above required content. R5 R5's diagnoses included lupus anticoagulation syndrome (an autoimmune disorder that causes blood clots to form in various parts of the body),	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 113	01700		

thrombosis (blood clot) of deep veins of unspecified lower extremity and history of pulmonary embolism (blood clot in the lung) with long term anticoagulation (blood thinning) management, glaucoma, heart murmur, high blood pressure, pulmonary fibrosis (condition where the lung tissue becomes damaged or scarred) and memory loss.

R5's service plan dated August 11, 2022, indicated R5 received services including medication administration.

R5's Medication Administration Record (MAR) dated October 2022, indicated R5 received medications to include four for glaucoma, one for blood thinning, one for high blood pressure, one eye supplement, one for high cholesterol, one for dry mouth, one nasal spray for allergies, and two additional supplements/vitamins.

On October 18, 2022, at approximately 8:45 a.m. ULP-E was observed to provide R5 oral medications and eye drops.

R5's Medication Self Administration assessment dated December 27, 2021, indicated self-administration ability for eye drops.

R5's most recent Medication Management Assessment dated May 27, 2022, indicated the following: 2. Medication Management-G. Medication administration-requires staff administration. And 3. regarding resident's ability to self-administer medications indicated A. "not applicable, plan already in place for staff to administer medications." 13. Does the resident have a complex medication regimen (9+ medications, warfarin, insulin, multiple psychotropics)? The record indicated the answer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 114 "A. No." The licensee failed to respond appropriately as R5 receives warfarin daily with varying doses specific to certain days. R5's MAR dated October 2022, indicated staff were administering two sets of eye drops three times daily to include: -Alphagan 0.1% ophthalmic solution-one drop into both eyes three times daily -dorzolamide 2% ophthalmic solution, one drop into both eyes three times daily R5's MAR dated October 2022, indicated R5 was self-administering the following medications: -latanoprost 0.005% ophthalmic solution (eye drops)-instill one drop into both eyes at bedtime-MAR indicated resident can keep these by the bedside and administer them herself. -Rhopressa 0.02% ophthalmic solution-instill one drop into both eyes at bedtime-MAR indicated resident may self-administer, please keep by the bedside. -Chlorhexidine 0.12% rinse-swish and spit 15 milliliters (ML) orally twice a day for dry mouth-MAR indicated self-administration. -Fluticasone 50 micrograms (mcg)-inhale two sprays in each nostril once daily- MAR indicated self-administration. The licensee failed to correctly assess R5's ability to self-administer eye drops, nasal spray, and oral rinse. On October 21, 2022, at 2:50 p.m. RN-C stated she was "uncertain about the process to re-evaluate or reassess resident's self-administration of medications but it made sense to reassess with each medication assessment/reassessment as done with staff managed medications."	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01700	Continued From page 115 The licensee's Initial and On-Going Nursing Assessment of Residents Under the Assisted Living License policy dated July 21, 2021, indicated a RN would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required for pre-admission assessment, 14 day assessment, ongoing assessment completed periodically but no less than every 90 days and for change in condition. A RN would complete assessments as indicated by individual resident circumstances. A comprehensive assessment included but may not be limited to the requirements outlined by Minnesota rules. The policy further indicated medication review including over the counter medications, prescription medications and supplements would include self-administration versus other type of administration. The RN would reassess the resident if the resident had a change in condition. On October 21, 2022, at 10:45 a.m. RN-C verified R5's Medication Management Assessment lacked the above required content. The licensee's Initial and On-going Nursing Assessment of Residents under the Assisted Living License policy dated August 1, 2021, indicated the licensee would provide a medication review including over the counter medications, prescription medications and supplements including, reason taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 116	01730		
01730 SS=E	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 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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 117	01730		

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 ensure an individualized medication management plan included all required content for five of five residents (R1, R2, R3, R4, R5).

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:

R1
R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including medication management and administration twice daily.

On October 18, 2022, at 8:43 a.m. R1 stated the licensee's staff provided the service of medication administration.

R1's Medication Management Assessment dated June 29, 2022, indicated medications were managed by the licensee's staff and R1 required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 118	01730		

staff administration of medications. Injections: insulin required staff administration. Meds would be stored in a locked med cart. The resident was compliant with taking medications, had no preferences in how to take medication, no difficulties in taking medication and had a complex medication regimen due to insulin. Interventions to prevent diversion: meds in locked med cart. Medications were discussed with the resident and the resident reports no problems.

R1's Medication Administration Record (MAR) dated October 2022, indicated staff were administering one medication used for increase in bone density, one used for heart prevention, two used to control high blood sugar, two used to help breathing, one used for anxiety, three used for supplement, one used to treat bacterial infection, one used for depression/anxiety, three used for allergies, two used for constipation, one used to treat low potassium levels, one used to treat underactive thyroid gland, two used for pain, two used to treat high blood pressure, one used for nausea/vomiting, one used to treat infection caused by fungus/yeast, one used to reduce inflammation, one used to treat high cholesterol, one used to treat and prevent ulcers, one used to treat migraine, one to reduce fluid in body, one used to dissolve gallstones, one used for eye allergies, one used for low blood sugar, one used to treat dizziness, one used for chest pain, one used for dry eyes and one used for muscle spasms.

R1's record/MAR lacked indication of storage of medication in a refrigerator for Basaglar KwikPen, Novolog FlexPen (insulins/used for high blood sugars) prior to use; lacked direction to take Alendronate sodium tablets (used for increase in bone density) at least one-half hour before the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 119 first food, beverage, or medication of the day (was scheduled to be given at 8:00 a.m. with other medications on the MAR); lacked direction to administer Prednisone with food (one used to reduce inflammation); lacked direction to take carafate (used to treat ulcers) on an empty stomach; lacked direction to rinse mouth after use for PRN (as needed) Ventolin inhaler (used to help breathing); lacked direction of when the nurse should be notified for administration of PRN nitroglycerin (used for chest pain); lacked parameters for which PRN medication to use first for dry eyes (cromolyn sodium 4% or Systane 0.6%); lacked parameters for PRN administration of glucose tablet two tablets as needed for low blood sugar (did not specify a number for results of low blood sugar reading); and lacked identified specific behaviors/symptoms, non pharmalogical interventions to attempt and monitoring of the behavioral symptoms to determine effectiveness of the medications for the use of Buspar (used for anxiety) and Cymbalta (used to treat anxiety/depression) medications. R1's individualized medication management record lacked the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; and -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On October 21, 2022, at 11:30 a.m. registered nurse (RN)-C verified R1's individualized medication management record lacked the above	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 120 content. RN-C stated, "I don't think so" to behavioral symptom monitoring in place for R1. R2 R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including medication management/administration twice daily. On October 18, 2022, at 9:02 a.m. ULP-H was observed to administer medications to R2. R2's Medication Management Assessment dated July 29, 2022, indicated medications were managed by the licensee's staff and R2 required staff administration of medications. Medications would be stored in locked med cart, nursing office or medication refrigerator at all times per manufacturer instructions. The resident was compliant with taking medications, had no preferences in how to take medication, no difficulties in taking medication and had a complex medication regimen. Interventions to prevent diversion: would be stored in locked med cart, nursing office or medication refrigerator at all times. Medications were discussed with the resident and the resident reports no problems. R2's MAR dated October 2022, indicated staff were administering six medications to help breathing, two used to treat anxiety, one used to treat seizures, two used to treat high blood pressure, one used to treat Alzheimer's disease, one used to treat infection of skin, one used to treat heartburn, one used to treat high cholesterol, one used for heart prevention, one used for depression, one used for eye allergy and one used for sleep. R2's record/MAR lacked direction to rinse mouth	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 121 after use for Incruse Ellipta inhaler, Spiriva inhaler, PRN Albuterol inhaler (all used to help breathing); lacked parameters for hours apart DuoNeb (used to help breathing) inhale fours times a day as needed and lorazepam (used for anxiety) twice daily as needed; lacked parameters for which PRN medication to administer first (albuterol, DuoNeb); lacked specific direction when the nurse should be notified for symptoms related to Depakote (used for seizures); and lacked identified specific behavioral symptoms, non pharmalogical interventions to attempt and monitoring of the behavioral symptoms to determine effectiveness of the medications for the use of Buspar, vilazodone (used to treat depression) and lorazepam PRN. R2's individualized medication management record lacked the following: -documentation of specific resident instructions relating to the administration of medications; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On October 21, 2022, at 12:48 p.m. RN-C verified R2's individualized medication management record lacked the above content. R3 R3's Service Plan Agreement dated August 2, 2022, indicated services included three meals daily, temperature daily, oximeter reading daily, housekeeping weekly, laundry wash, pick up and delivery once weekly. The service plan lacked the service of medication administration. On October 18, 2022, at 9:49 a.m. ULP-J was observed to administer medications to R3.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 122 On October 18, 2022, at 10:10 a.m. R3 stated the licensee's staff provided the services of medication administration. During the interview with R3, the following medications were observed in R3's living room area: albuterol/Ventolin inhalers (provides relief for breathing difficulties), Breo inhaler (provides relief for breathing difficulties), Desenex powder (used to treat skin infections), Aspercreme liquid (used for pain), Biofreeze (used for pain), Nicoderm 14 milligram (mg) patches (helps quit smoking) and diclofenac sodium 1% gel (used for pain). R3's Medication Management Assessment dated August 3, 2022, indicated medications were managed by the licensee's staff and R3 required staff administration of medications. R3's ability to self-administration of medications was not applicable due to plan was in place for staff to administer medications. Medications would be stored in locked med cart, nursing office or medication refrigerator at all times per manufacturer instructions. The resident was compliant with taking medications and had a complex medication regimen. Interventions to prevent diversion: would be stored in locked med cart, nursing office or medication refrigerator at all times. Medications were discussed with the resident and the resident reports no problems. R3's MAR dated October 2022, indicated staff were administering one medication used for anxiety, two used for supplement, three used to treat high blood pressure, one used to prevent blood clots, one used to treat depression, one used to reduce fluid in the body, one used to treat movements in face/tongue/or other body parts that cannot be controlled, one used to treat low potassium levels, one used to treat multiple	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 123 myeloma (cancer), one used to treat schizophrenia/bipolar disorder, one used to treat infections, three used to help breathing, one used for virus infections, three used to treat pain, one used to treat diarrhea and one used to treat skin condition (itchy or red irritation). R3's record/MAR lacked direction to rinse mouth after use of symbicort inhaler, combivent inhaler, albuterol inhaler (all used to help breathing); lacked parameters for hours apart combivent, loperamide (four times a day as needed) and triamcinolone ointment (twice daily as needed); lacked parameters for which PRN medication to administer first for shortness of breath (albuterol or combivent) and for pain (diclofenac sodium gel or Tylenol); lacked specific direction when the nurse should be notified for symptoms related to use of Eliquis (used to prevent blood clots) and use of valtrex (used for virus infections); and lacked identified specific behavioral symptoms, non pharmalogical interventions to attempt and monitoring of the behavioral symptoms to determine effectiveness of the medications for the use of Buspar, Lexapro (used to treat depression/anxiety) and risperidone (schizophrenia/bipolar disorder). R3's individualized medication management record lacked the following: -documentation of specific resident instructions relating to the administration of medications; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On October 21, 2022, at 1:19 p.m. RN-C verified R3's individualized medication management record lacked the above content.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 124 R4 R4's diagnoses included type 2 diabetes (when a person's pancreas cannot create sufficient insulin to manage blood sugar), history of falls, anxiety, depression, and chronic kidney disease. R4's service plan dated July 29, 2022, indicated R4 received services to include medication administration. R4's Medication Administration Record (MAR) dated October 2022, indicated R4 received medications to include two medications for pain, one for gout, one for depression, two for blood sugar management, two for asthma and shortness of breath, one for gastroesophageal reflux, one for high cholesterol, one for urinary tract infection maintenance/prevention, one for allergies, one for constipation, one for anxiety, and one for sleep. On October 18, 2022, at approximately 8:00 a.m. ULP-E was observed to provide oral medications and an insulin injection to R4. R4's Medication Management Assessment dated June 21, 2022, indicated R4 required staff administration for medications and required "another person administration" for insulin injections. R4's Service plan dated July 29, 2022, indicated R4 medication service type was "Med Management-Setup and admin" and included notes that read "Nurse-If setting up medications in a caddy or filling syringes, include name of each medication to be set up, strength/dose, times of administration and route. Medications will be set up for 28 days unless otherwise recorded	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 125 in the Service plan. All medications are delivered by pharmacy every other week and as needed, reviewed by nurse and administered by staff trained to administer medications." R4's service plan lacked verbiage as seen in other licensee resident records to include the following: - specific instructions and frequency of services to refer to PCP (primary care provider) orders or see EMAR/Tasks - the statement "the above items may be delegated to trained unlicensed employees. The services to be provided would be documented in detail on the service plan and/or EMAR. This shall serve as the medication/treatment/therapy assessment and plan." R4's record lacked required content to include: medication reconciliation to be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. The licensee failed to ensure the proper medication service type was indicated on R4's service agreement or medication plan and lacked required content of a medication plan. R5 R5's diagnoses included lupus anticoagulation syndrome (an autoimmune disorder that causes blood clots to form in various parts of the body), thrombosis (blood clot) of deep veins of unspecified lower extremity and history of pulmonary embolism (blood clot in the lung) with long term anticoagulation (blood thinning) management, glaucoma, heart murmur, high blood pressure, pulmonary fibrosis (condition where the lung tissue becomes damaged or	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 126 scarred) and memory loss. R5's service plan dated August 11, 2022, indicated R5 received services to include medication administration. R5's Medication Administration Record (MAR) dated October 2022, indicated R5 received medications to include three (eye drops) for glaucoma, one for blood thinning, one for high blood pressure, one eye supplement, one for high cholesterol, one for dry mouth, one nasal spray for allergies, and two additional supplements/vitamins. R5's MAR dated October 2022, indicated R5 self-administered the following medications: Chlorhexidine 0.112% rinse, 15 milliliters (ml) twice daily (for dry mouth); fluticasone 50 micrograms (mcg), two sprays in each nostril once daily (for allergies); and latanoprost 0.005% ophthalmic solution (eye drops for glaucoma) one drop at bedtime, included the direction "resident can keep at the bedside and administer them herself." On October 18, 2022, at approximately 8:45 a.m. ULP-E was observed to provide R5's oral medications and eye drops. R5's Medication Self Administration Assessment dated December 27, 2021, in section 13. can correctly administer eye drops or eye ointments, the entry indicated was "D. Able." Additionally, section 23. indicated "This resident is assessed to be able to safely self-administer medications." R5's Medication Management Assessment dated May 27, 2022, section 2. Medication management, indicated "G. Medication administration-requires staff administration." Then	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 127 section 3. Resident demonstrates an ability to self-administer medications. The entry indicated "A. Not applicable, plan already in place for staff to administer medications." R5's medication plan (found in the service plan) lacked a statement indicating R5 was able to self-administer eye drops at bedtime. R5's record lacked a reassessment of R5's ability to self administer eye drops, oral rinse, and nasal spray after the medication assessment dated May 27, 2022, indicated staff to administer medications, yet R5 continued to self-administer bedtime eye drops. On October 21, 2022, at approximately 10:20 a.m. RN-C verified the record had conflicting information regarding R5's ability for medication self administration. The licensee's Medication Management Individualized Plan policy dated August 2021, indicated the licensee would develop and maintain a current individualized medication management record for each resident based on the resident assessment and would contain the required content according to 144G.71 Subd. 5. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy dated July 21, 2021, indicated the RN would instruct and competency test the unlicensed personnel on the following topics and tasks before delegating to them the task of medication administration, treatment and therapy. "c. The complete procedure for checking a resident's record and the nurse's written procedure specific to the resident for the	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01730	Continued From page 128 administration of any delegated tasks. This included procedures for administration of any over the counter medications, PRN [as needed] medications, dietary supplements or treatment and therapy that our assisted living has agreed to provide to the resident. d. Procedures for the proper methods to administer medications, treatment and therapy to the resident." The licensee's Administration and Documentation of PRN Medications policy dated August 1, 2021, indicated the RN would review PRN prescriptions to ensure the prescription clearly identifies symptoms for which the PRN was prescribes, the frequency the PRN may be administered and if parameters for PRN were unclear the RN would follow up with the prescriber to obtain necessary information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01750	Continued From page 129 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee administered according to manufacturer's instructions observed with insulin administration for two of four residents (R8 and R2). 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: R8 On October 18, 2022, at 9:15 a.m. unlicensed personnel (ULP)-H was observed to administer Aspart insulin to R8 by injection via an insulin FlexPen. ULP-H attached a needle to the insulin pen and dialed up to four units of insulin on the pen. The surveyor intervened and asked ULP-H if she had primed the insulin pen with two (2 units) of insulin prior to dialing up the four units. ULP-H had ULP-D come into R8's apartment for direction. ULP-D informed ULP-H she had to prime the insulin pen with two units of insulin prior to dialing up the four units to be administered. The manufacturer guidelines for "Insulin Aspart FlexPen" dated revised November 2019, (provided by the licensee) indicated pull off the pen cap. Wipe the rubber stopper with an alcohol	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01750	Continued From page 130	01750		

swab and attach the needle. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injection air and to ensure proper dosing: turn the dose selector to select "2 units". Hold the insulin pen with the needle pointing up, tap the cartridge gently withe finger a few times to make any air bubbles collect at the top of the cartridge and press the push button all the way in. The dose selector returns to "0". A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. Check and make sure the dose selector is et at "0". Turn the dose selector to the number of units you need to inject.

ULP-H did not cleanse the rubber stopper with an alcohol pad prior to attaching the needle and did not prime the insulin pen with two units of insulin prior to dialing up the four units of insulin as per manufacturer instructions.

On October 19, 2022, at 1:29 p.m. registered nurse (RN)-C stated the rubber stopper on the insulin pen should be cleansed with an alcohol pad prior to attaching the needle and should be primed with two units prior to dialing up the dose of insulin to be administered.

R2
R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including medication management/administration twice daily.

On October 18, 2022, at 9:02 a.m. ULP-H was observed to administer medications to R2, including Symbicort (used to help breathing) two puffs by mouth and Advair Diskus (used to help

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01750	Continued From page 131	01750		

breathing) one puff by mouth. ULP-H administered the inhalers one right after the other (no time wait between inhalers) and did not offer R2 the opportunity to rinse mouth after each inhaler.

The website https://aplmed.com for "6.12 Steps and Procedures for Different Routes of Medication Administration (Inhalation)" dated 2022, indicated "Spacing and proper sequence of the different inhalers is important for maximal drug Effectiveness; The prescribing practitioner may specifically order the sequence of administration if multiple inhalers are prescribed or the pharmacy may provide instruction on the medication label or MAR; Wait at least one minute between puffs for multiple inhalations; It is best to have clients rinse their mouth after administering inhalants. Many times, inhalants taste bitter or can cause thrush".

On October 19, 2022, at 1:29 p.m. RN-C stated, "Generally wait at least five minutes" between administration of different inhalers. RN-C stated the resident should be offered to rinse their mouth after the administration of inhaler medications.

The licensee's Delegated Nursing Task with Medications: Insulin Injection: Pen undated, indicated wipe rubber stopper with alcohol swab, after attaching the needle turn the dose selector to two units while holding the pen with the needle pointing up, press the push-button all the way until the dose selector is back to 0. Double check the ordered dose of insulin. Documentation of administration would include dose and site on the MAR.

The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01750	Continued From page 132 policy dated August 1, 2021, indicated unlicensed personal that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN. Medications, treatment and therapy always need to be administered according to the "6 Rights". The RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or delegate administration of medications, treatment and therapy if the ULP has satisfied the training requirements of demonstrated ability to completely follow the procedures, the RN has developed written, specific instruction for each resident and the RN has documented that the ULP have been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01760	Continued From page 133 with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medications were administered as ordered for two of four residents (R1 and R4). 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: R1 R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including medication management and administration twice daily. On October 18, 2022, at 8:43 a.m. R1 stated the licensee's staff provided the service of giving medications. R1's MAR dated October 2022, lacked the following: -signature for the administration of medications or documented reason why the medication were not administered on October 1, 2022, for medication scheduled to be given at 8:00 p.m. (one used for	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01760	Continued From page 134 anxiety, two used for allergies, three used for pain, two used to treat high blood pressure, one used for nausea, one used to treat control high blood sugar, one used to treat infection caused by fungus/yeast, one used to treat high cholesterol, one used for constipation, one used to treat and prevent ulcers, one used to treat migraine and one used to dissolve gallstones). -documentation of units of Novolog insulin administered per sliding scale four times daily with meals and at bedtime On October 21, 2022, at 11:30 a.m. RN-C verified R1's record lacked the above content. R4 R4's diagnoses included type 2 diabetes (when a person's pancreas cannot create sufficient insulin to manage blood sugar), history of falls, anxiety, depression, and chronic kidney disease. R4's service plan dated July 29, 2022, indicated R4 received services to include medication administration. R4's Medication Administration Record (MAR) dated October 2022, included Humalog (insulin) 100 unit/milliliters (ml), inject six units subcutaneous three times daily with meals along with sliding scale. The sliding scale was written when blood sugars (BS) were in a certain range, additional Humalog insulin was added to the base amount of six units. The scale was written as: BS 180-219 + two units BS 220-259 + three units BS 260-299 + four units BS 300-339 + five units BS 340-379 + six units	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01760	Continued From page 135 BS 380-399 + seven units greater than 399 call MD On October 18, 2022, at approximately 8:00 a.m. unlicensed personnel (ULP)-E was observed to provide a blood sugar check, oral medications, and insulin injection to R4. R4's BS was 160 which indicated R4 received six units of Humalog without the need for additional units of insulin. ULP-E injected six units of Humalog insulin into R4's right lower abdomen. R4's MAR included areas for staff to input their initials when additional units of Humalog insulin were administered, but failed to indicate how many additional units of insulin were administered to R4. On October 19, 2022 at 3:00 p.m. RN-C verified there was no documentation of R4's sliding scale insulin. RN-C stated she did not know how the licensee managed edits to the MAR or record to include this information. The licensee's Medication and treatment orders policy (7.20) indicated the licensed nurse would review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change in condition. The licensed nurse will monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. And a resident's MAR and TAR (treatment administration record) would be audited regularly by a licensed nurse or designee for documentation compliance. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, indicated staff would	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01760	Continued From page 136 document each task immediately after that tasks has been performed. Documentation would follow professional standards for documentation. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated unlicensed personal that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN. Medications, treatment and therapy always need to be administered according to the "6 Rights". The RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or delegate administration of medications, treatment and therapy if the ULP has satisfied the training requirements of demonstrated ability to completely follow the procedures, the RN has developed written, specific instruction for each resident and the RN has documented that the ULP have been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD TO CORRECT- Seven (7) days.	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01790	Continued From page 137 (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01790	Continued From page 138 registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for providing medications for residents having unplanned time away, and the unlicensed personnel (ULP) providing medications when the licensed nurse was not available. In addition, the RN failed to ensure one of three unlicensed personnel (ULP-H) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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: The licensee's Delegation of Medication to be	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01790	Continued From page 139	01790		

given to Residents by Unlicensed Staff for Residents Time Away from Home dated August 1, 2021, lacked the following required content for unplanned time away:
- the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
- the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
-the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
- the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident.
The procedures must address:
- the type of container or containers to be used for the medications appropriate to the provider's medication system;
- how the container or containers must be labeled;
-written information about the medications to be provided;
- a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel.

On October 21, 2022, at 10:30 a.m. RN-C stated she was unaware of the content requirement for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01790	Continued From page 140 the planned and unplanned time away policy and would have to look at it. ULP-H ULP-H had a hire date of August 17, 2021. On October 18, 2022, at 9:02 a.m. ULP-H was observed to administer medications to R2. ULP-H's 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks dated February 4, 2022, indicated for "preparing meds for LOA" (leave of absence) under "competent" was documented "NA" (not applicable). ULP-H's record lacked evidence to indicate the RN provided training and determined competency to prepare and administer medications to residents for unplanned times away. ULP-I ULP-I had a hire date of December 28, 2021. ULP-I's 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks dated February 4, 2022, indicated for "preparing meds for LOA" under "competent" "Yes" was circled; however, there was no evidence of a written procedure for ULP to prepare medications for a LOA. On October 21, 2022, at 10:30 a.m. RN-C verified ULP sent medications with residents for unplanned time away. The surveyor requested written procedures used for training and competency of delegated tasks from RN-C. RN-C stated she had not personally developed a procedure for the ULP to follow for setting up medications if a resident had unplanned time away. RN-C stated she would look for the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01790	Continued From page 141 procedure for unplanned time away used to train and competency the ULP and would provide step by step written procedure used for training and competency of activities of daily living and medications. On October 21, 2022, at 2:47 p.m. ULP-D stated ULP-H and ULP-I's 30 Day and/or Periodic Supervision of Staff Providing Delegated Medication Tasks dated February 4, 2022, was the RN documented competency for medication administration tasks (not a 30-day supervision task as titled). RN-C and ULP-D verified ULP-H's record lacked training and determined competency to prepare and administer medications to residents for unplanned times away. The surveyor was given written procedures provided by the licensee for delegated tasks; however, the delegated written procedures provided did not include any written procedures for medications, including a procedure for unplanned time away. The licensee's Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy dated July 21, 2021, indicated the RN would instruct and competency test the unlicensed personnel on the following topics and tasks before delegating to them the task of medication administration, treatment and therapy. "c. The complete procedure for checking a resident's record and the nurse's written procedure specific to the resident for the administration of any delegated tasks. This included procedures for administration of any over the counter medications, PRN [as needed] medications, dietary supplements or treatment and therapy that our assisted living has agreed to provide to the resident. d. Procedures for the	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01790	Continued From page 142 proper methods to administer medications, treatment and therapy to the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescriber's orders for medications for one of five residents (R2). 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: R2's diagnoses included ureteroileal conduit, spina bifida with hydrocephalus, mobility impaired.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01820	Continued From page 143 R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including medication management/administration twice daily. On October 18, 2022, at 9:02 a.m. ULP-H was observed to administer medications to R2. R2's Medication Administration Record (MAR) dated October 2022, indicated staff were administering six medications to help breathing, two used to treat anxiety, one used to treat seizures, two used to treat high blood pressure, one used to treat Alzheimer's disease, one used to treat infection of skin, one used to treat heartburn, one used to treat high cholesterol, one used for heart prevention, one used for depression, one used for eye allergy and one used for sleep. The following dated prescriber's orders for medications were provided by the licensee and included the following: Current Medications as of July 26, 2022. The orders included: - Colesevelam HCl 625 mg tablet (Welchol) (used to lower cholesterol) take three tablets by mouth twice daily; - Nystatin Powder (used to treat fungus infection) apply to affected area twice daily as needed; - critic-aid (used to protect skin) clear for perineal skin breakdown, after each bowel movement (BM); - Vibryd (used to treat depression) 40 mg tablet take one tablet daily; and - ondansetron (used to prevent nausea and vomiting) 8 mg tablet take every 12 hours as needed for nausea.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01820	Continued From page 144 R2's MAR, dated October 2022, lacked inclusion of medications as per prescriber's orders. In addition, it further indicated the Vibryd 40 mg tablet was discontinued effective October 3, 2022, but there was no evidence of prescriber orders for the discontinuation. In addition, the orders included Ventolin 108 mcg (albuterol) (used to help breathing) inhaler - inhale one to two puffs by mouth every 4 to 6 hours as needed and as directed; however R2's MAR indicated albuterol (Ventolin) inhaler inhale 2 puffs every 4 hours as needed with effective date of April 25, 2022. The MAR lacked direction every "4 to 6 hours" for the Ventolin inhaler as prescribed, nor was a prescriber's order provided for the order change. - After Visit Summary dated September 15, 2022, gave direction to "stop taking WelChol 625 mg tablet" and indicated "continue" budesonide-formoterol 160-4.5 mcg inhaler (Symbicort) (used to help breathing) - inhale 2 puffs two times a day; however, the document was not signed by a physician. R2's MAR lacked continued administration of the Welchol medication and a signed prescriber's order for the discontinuation of the medication was not provided. In addition, R2's MAR identified staff were administering the Symbicort, but a prescriber's order for the administration of the Symbicort was not provided. -After Visit Summary dated September 25, 2022, was provided; however, pages 10 through 13 were not provided for the 17 page document. The medication list on pages 14 and 15 included Vibryd 40 mg tablet take one tablet daily. R2's MAR indicated the Vibryd 40 mg tablet was discontinued on October 3, 2022. A prescriber's	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01820	Continued From page 145 order for discontinuation of the medications was not provided. R2's MAR also included microgaurd 2% topical powder (Lotrimin) (used to treat athlete's foot) apply twice daily during wound cleansing; however, no prescriber's order was provided for the Lotrimin medication. On October 21, 2022, at 12:48 p.m. registered nurse (RN)-C verified R2's record lacked the above and she would look for further information regarding prescriber orders for R2. The licensee's Documentation of Medications, Treatment and Therapy Management Services policy dated August 1, 2021, indicated for receiving and requesting prescriptions and refills the RN would document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for residents, including communications with the prescriber and pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 146 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; (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 ensure prepare and include a treatment plan to include all required content for two of three residents (R1, R2). 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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 147 situation has occurred only occasionally). The findings include: R1 R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including skin care (the resident assistant will verbally report any changes to the skin such as open areas, drainage or redness to the nurse. R1's service plan lacked the treatment services of blood sugar checks, wound dressing changes, ace wraps (compression wraps used to reduce swelling), short stretch wraps (low elasticity bandages used to reduce swelling), Velcro compression garments (compression wrap used to reduce swelling), Jobst stockings (used to reduce swelling) and CPAP use (a medical device used to obtain continuous positive airway pressure). On October 18, 2022, at 8:43 a.m. R1 stated a "wound nurse" comes to the facility "two times a week on Monday and Friday" to provide "wound cares". R1 stated she had "cellulitis" in both legs, and she had two open areas on the right leg and one open area on the left leg. R1 stated she had "one big and one small joined" wound on bottom. On October 19, 2022, at 8:43 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and provide wound dressing changes to R1's left and right lower extremities, umbilical area, coccyx area and right and left buttocks. ULP-D removed ace wrap and wound dressing from R1's left lower leg/foot. R1's left foot was observed to have an open area on the side of the little toe and a closed black colored area on the side of great toe. ULP-D cleansed R1's right lower leg/foot with acetic acid (used for the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 148	01940		

treatment of infections of skin), taped two abdominal (ABD) pads (absorbent pad) together around R1's lower leg and wrapped gauze cling wrap around lower left foot/leg. ULP-D removed two ace wraps and wound dressing from R1's right lower leg/foot. R1's right foot was observed to have an open area on the side of the little toe and R1's upper outer right side lower leg had an intact blister. Scant purple colored bruising was noted on top of R1's right foot and top end of R1's great toe. ULP-D stated she noticed the blistered area last Friday. ULP-D removed a Mepilex dressing (antimicrobial foam dressing) from the outer side of R1's foot. The skin was intact underneath the dressing. ULP-D stated about two weeks ago the skin area under the Mepilex on R1's outer right side of foot was blistered and opened. ULP-D stated R1 had lymphedema. ULP-D cleansed R1's lower right leg/foot with acetic acid, applied a Mepilex dressing to the right outer blister on R1's upper lower leg and outer side of R1's right foot, taped three smaller ABD pads together around R1's lower leg and wrapped gauze cling wrap around lower right foot/leg. ULP-D applied one ace wrap spirally around to R1's left and right lower foot/leg. ULP-D asked R1 if she wanted her to change the dressing to her "belly button" area. ULP-D removed Mepilex dressing from the area. The skin was intact. ULP-D cleansed the skin with acetic acid and applied a Mepilex dressing. ULP-D had R1 roll over in bed. A foam white pad dressing was in place on R1's right buttock and left buttock. ULP-D removed the white foam pads from R1's right and left buttocks. The skin underneath the foam pads was open. R1's coccyx area had no dressing in place. ULP-D asked R1 if the Mepilex dressing fell off the coccyx area. ULP-D stated the open area on R1's coccyx "has gotten worse". ULP-D cleansed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 149 coccyx area with a dry disposable pad cloth. ULP-D stated "I can put my finger in the hole" while placing tip of index finger into the area. ULP-D applied thick moisture barrier paste to R1's coccyx wound. ULP-D called registered nurse (RN)-C into R1's room. RN-C came into R1's room and ULP-D informed RN-C R1's coccyx area had "a hole now." R1 stated "It's so sore" in regards to her buttocks and coccyx areas. ULP-D stated to RN-C "I put my finger in there" referring to the wound on R1's coccyx. ULP-D showed RN-C how deep the coccyx wound hole was by finger depth of using her index finger. ULP-D applied a large, padded dressing which covered both buttocks and coccyx areas. ULP-D showed the surveyor two previous open areas on R1's right thigh and one on the back left thigh, which she stated were present when R1 was admitted but were now healed. A sheet of paper was noted to be in R1's room to be orders for "wound care: leg, abdomen, foot, coccyx, buttocks, leg, foot. Prevention of pressure: abdomen. Mixed etiology: buttock and coccyx" dated September 16, 2022. ULP-D stated "they aren't current orders. I looked at the MAR [medication administration record] before coming in" (to R1's room). ULP-D stated directions for wound treatment to the areas on R1's left/right lower feet/legs/buttocks and coccyx were located on the MAR. ULP-D stated, "Staff do the best they can with how trained", regarding providing wound dressing changes to the above areas. ULP-D stated the wound dressing changes were to be completed daily. R1's record included the following prescriber's orders for treatments: -CPAP prescription dated October 20, 2021. -Bluestone Vista/Extended Care clinic note dated October 4, 2022, included acetic acid 0.25%	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 150	01940		

irrigation solution use to irrigate the affected area once daily. Open bottle good for 24 hours, contour Next Monitor device kit use to test blood sugars "5" (five) times "QD" (every day), Jobst knee high stockings and Velcro compression wraps bilateral lower legs.
-Department of Surgery, Wound and Ostomy Care note dated October 11, 2022, indicated bilateral leg and buttock wounds, here for recheck. Resides at assisted living and home care is assisting with dressings. Currently on antibiotic after presenting to ER (emergency room) over the weekend with symptoms of cellulitis. She is wearing short stretch wraps to legs today. Longstanding lymphedema bilaterally. "Left foot ulcers: will protect this foot with dressing for another week then d/c [discontinue]. Left posterior calf ulcer: apply promogran [topical wound treatment containing collagen, oxidized-regenerated cellulose and 1% silver] to the ulcer and cover with a bordered foam. Right buttock/coccyx ulcers: there are three open areas (one on right buttock, sacral area and 2 at the coccyx at the gluteal cleft. These 2 are slightly deeper). Will start Triad wound dressing [sterile coating applied directly onto the wound] covered with a bordered foam. Venous insufficiency/lymphedema: will need ongoing compression and elevation. Does have Velcro compression garments and Jobst stockings to wear, okay to transition anytime. Today applied short stretch wraps bilaterally on the lower legs".

R1's Medication Administration Record (MAR) dated October 2022, included the following:
-acetic acid 0.25 percent (%) irrigation solution - use to irrigate the affected area once daily
-blood glucose monitoring (scheduled for four times a day) have resident wash hands with soap and water. Remove her glucometer (medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 151 device used to check level of sugar in blood) from the drawer and remove a strip (testing strip used to place blood on and inserted into a glucometer) from the canister. Put a new lancet (finger stick device to obtain blood for testing blood sugar) in her lancet device and hand unit to her. She will press the button and put a drop of blood on the strip. Have her remove the the lancet from the lancet device and place it in the sharps (container used to dispose needles in). Record the blood sugar. Return equipment to her drawer. If blood sugar is below 90 or above 350 notify the nurse. -dressing change with abdominal pad to bilateral legs two times a day. Wash affected area with mild soap and dry. Apply prescribed dressing to ulcer area. R1's Service Checkoff List dated October , 2022, included the following: -blood sugar - monitor blood sugar four times per day. If blood sugar below 90 or above 350 notify the nurse. If blood sugar is below goal range, describe carb - food/fluid given in note. Chart if not needed. The resident assistant (RA) will verbally report any blood sugar results out of the resident's identified normal range to the nurse. Document another blood sugar test if result was less than goal range and intervention was completed. -skin care - resident assistant to apply lotion to lower extremities. Resident receives wound care 8 a.m. and 8 p.m. See treatment administration record (TAR) for instructions. The resident assistant will verbally report any changes to the skin such as as open areas, drainage or redness to the nurse. R1's Medication Management Assessment dated June 29, 2022, indicated "No" for resident requiring assistance to complete treatments.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 152 "N/A" (not applicable) for does resident understand the purpose and schedule for treatments (i.e. compression stockings, oxygen, skin care, etc.) that are prescriber ordered. "Yes" for are prescriber ordered treatments effective. "Yes" for education was provided to resident/family about treatment or therapy they are receiving. R1's record lacked an individualized treatment/therapy management record for the treatments of blood sugar checks, wound dressing changes, ace wraps, short stretch wraps, Velcro compression garments, Jobst stockings and CPAP including the following: -a statement of the type of services that would be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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. On October 19, 2022, at 1:29 p.m. RN-C informed she started working for the licensee on August 2, 2022. RN-C stated she had no prior assisted living experience. RN-C stated, "I am learning it." RN-C stated, "I have not done anything with [R1's] wounds".	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 153 On October 20, 2022, at 1:08 p.m. ULP-D stated R1 used a CPAP. ULP-D stated R1's prescriber order for her CPAP was expired. ULP-D stated R1's Department of Surgery, Wound and Ostomy Care note dated October 11, 2022, were the current prescriber orders for R1's wounds and Bluestone note dated October 4, 2022, were the current prescriber orders from R1's primary physician. On October 21, 2022, at 11:30 a.m. RN-C verified R1's record lacked an individualized treatment/therapy plan for treatment services being provided by the licensee. R2 R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including ostomy, compression stocking assist, and colostomy assistance. R2's service plan lacked the treatment services of nephrostomy tube (a thin catheter placed into kidney to drain urine) site cares and Urostomy stoma (an opening in the abdominal wall that redirects urine away from the bladder) site/catheter bag cares. On October 18, 2022, at 8:08 a.m. R2 laid in bed and was observed to have a Urostomy (right side abdomen) and nephrostomy tubes on right and left sides (kidney areas). ULP-G and ULP-I were observed to empty R2's nephrostomy catheter bags (right and left sides) and Urostomy catheter bag. ULP-G and ULP-D were observed to provide nephrostomy tube site cares to R2. ULP-G stated the dressing for the nephrostomy tube sites were to be changed daily. ULP-G removed the dressing from the left side nephrostomy tube site and cleansed around the site with an alcohol pad. ULP-G folded in half a 4 x 4 gauze pad and placed the folded gauze underneath the tube and	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 154 secured the gauze with tape. ULP-D removed the dressing from right side nephrostomy tube site, cleansed around the site with acetic acid using a gauze pad, used scissors to cut a slit into a non-stick pad, placed the non-stick pad around the tube site and secured the pad with tape. ULP-D removed the dressing from around the right tube site which ULP-G had applied, cleansed around the site with the same gauze (with acetic acid on it) and applied a split non-stick dressing secured with tape around the site. R2's record included the following prescriber's orders for treatments: -July 26, 2022, compression socks knee high, bilateral. -August 24, 2022, Urostomy - the patient's ordered puching system is a two piece pouch. Pouch order Hollister 1687, accessories: skin barrier ring (120700), ostomy belt and protective seal 12037, night bag. Instructions were given to patient who verbalized understanding, given to caregiver who verbalized understanding. In case of bleeding hold pressure for 5-10 minutes. If does not stop seek emergency care. -September 20, 2022, hospital After Visit Summary indicated dates September 14, 2022, to September 20, 2022, and diagnosis infection urinary tract. Since September 15, 2022, interval placement of bilateral percutaneous nephrostomy tubes. Nephrostomy tubes to be kept to gravity; cleanse around tube sites every other day with soap and water, dry well and place split gauze around the tube insertion site, cover with dry gauze, change every other day or sooner if soilage of the gauze is noted. Urostomy - go back to usual pouches, skin care and pouch changes. R2's MAR dated October 2022, included the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 155 following: -acetic acid 0.25 percent (%) irrigation solution - use twice daily for wound cleansing R2's Service Checkoff List dated October, 2022, included the following: -colostomy assistance - resident has colostomy, assist with changing every other day and as needed. Adhesive wipe to remove left over adhesive on skin. Remove old bag. Spray adhesive spray on new appliance and pace around colostomy. Snap bag onto appliance. Resident can walk you through it. Resident assistant will report any skin changes around the colostomy site or problems with colostomy equipment to nurse. -compression stockings - resident assistant will apply compression stockings in the morning and remove at bedtime. The RA will verbally report any open areas or redness on the skin that does not disappear to the nurse. -ostomy - empty nephrostomy drainage bags if needed and clean around the site. The resident assistant will report any skin changes around the ostomy site or problems with equipment to the nurse. The stoma will be pink or red, moist, and a little shiny. Contact nurse "ASAP" (as soon as possible) if any issues or concerns. -Ostomy as needed (PRN) has Urostomy, assist with changing every other day and as needed. Adhesive wipe to remove left over adhesive on skin. Remove old bag. Spray adhesive spray on new appliance and pace around Urostomy. Snap bag onto appliance. Resident can walk you through it. Resident assistant will report any skin changes around the ostomy site or problems with colostomy equipment to nurse. The stoma will be pink or red, moist, and a little shiny. Contact nurse ASAP if any issues or concerns.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 156	01940		

R2's record lacked an individualized treatment/therapy management record for the treatments of nephrostomy tube site/bag cares, compression stockings and Urostomy site/bag cares including the following:
-a statement of the type of services that would be provided;
-documentation of specific resident instructions relating to the treatments or therapy administration;
-identification of treatment or therapy tasks that will be delegated to unlicensed personnel;
-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and
-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.

On October 21, 2022, at 12:48 p.m. RN-C confirmed R2 did not have a finalized service plan. She had printed the service plan agreement and did not review the service plan prior to obtaining R2's signature on October 18, 2022. RN-C verified R2's record lacked an individualized treatment/therapy plan for treatment services being provided by the licensee. RN-C verified the licensee was providing treatment services for R2. RN-C stated R2 did not have a colostomy as indicated above, but had a Urostomy.

The licensee's Treatment and Therapy Management Plan policy dated August 2021, indicated the licensee would develop and maintain a current individualized treatment and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01940	Continued From page 157 therapy management record for each resident and would contain the required content according to 144G.72 Subd. 3. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an the registered nurse (RN) specified, in writing,	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 158 specific instructions for each resident and documented those instructions in the resident's records for two of three residents (R1, R2); and had instructed the unlicensed personnel in the proper methods with respect to each resident and three of three unlicensed personnel (ULP-G, ULP-H, ULP-I) has demonstrated the ability to competently follow the procedures. 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: R1 R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including skin care (the resident assistant will verbally report any changes to the skin such as open areas, drainage or redness to the nurse. The nurse will review the results at least every 90 days to update the prescriber as indicated). R1's service plan lacked the treatment services of blood sugar checks, wound dressing changes, ace wraps (compression wraps used to reduce swelling), short stretch wraps (low elasticity bandages used to reduce swelling), Velcro compression garments (compression wrap used to reduce swelling), Jobst stockings (used to reduce swelling) and CPAP use (a medical device used to obtain continuous positive airway	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 159 pressure). On October 18, 2022, at 8:43 a.m. R1 stated a "wound nurse" comes to the facility "two times a week on Monday and Friday" to provide "wound cares." R1 stated she had "cellulitis" in both legs, and she had two open areas on the right leg and one open area on the left leg. R1 stated she had "one big and one small joined" wound on her bottom. On October 19, 2022, at 8:43 a.m. unlicensed personnel (ULP)-D was observed to provide wound dressing changes to R1's left and right lower extremities, umbilical area, coccyx area and right and left buttocks. ULP-D removed ace wrap and wound dressing from R1's left lower leg/foot. R1's left foot was observed to have an open area on the side of the little toe and a closed black colored area on the side of great toe. ULP-D cleansed R1's right lower leg/foot with acetic acid (used for the treatment of infections of skin), taped two abdominal (ABD) pads (absorbent pad) together around R1's lower leg and wrapped gauze cling wrap around lower left foot/leg. ULP-D removed two ace wraps and wound dressing from R1's right lower leg/foot. R1's right foot was observed to have an open area on the side of the little toe and R1's upper outer right side lower leg had an intact blister. Scant purple colored bruising was noted on top of R1's right foot and top end of R1's great toe. ULP-D stated she noticed the blistered area last Friday. ULP-D removed a Mepilex dressing (antimicrobial foam dressing) from the outer side of R1's foot. The skin was intact underneath the dressing. ULP-D stated about two weeks ago the skin area under the Mepilex on R1's outer right side of foot was blistered and opened. ULP-D stated R1 had lymphedema. ULP-D cleansed R1's lower right	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 160	01950		

leg/foot with acetic acid, applied a Mepilex dressing to the right outer blister on R1's upper lower leg and outer side of R1's right foot, taped three smaller ABD pads together around R1's lower leg and wrapped gauze cling wrap around lower right foot/leg. ULP-D applied one ace wrap spirally around to R1's left and right lower foot/leg. ULP-D asked R1 if she wanted her to change the dressing to her "belly button" area. ULP-D removed Mepilex dressing from the area. The skin was intact. ULP-D cleansed the skin with acetic acid and applied a Mepilex dressing. ULP-D had R1 roll over in bed. A foam white pad dressing was in place on R1's right buttock and left buttock. ULP-D removed the white foam pads from R1's right and left buttocks. The skin underneath the foam pads was open. R1's coccyx area had no dressing in place. ULP-D asked R1 if the Mepilex dressing fell off the coccyx area. ULP-D stated the open area on R1's coccyx "has gotten worse". ULP-D cleansed the coccyx area with a dry disposable pad cloth. ULP-D stated "I can put my finger in the hole" while placing tip of index finger into the area. ULP-D applied thick moisture barrier paste to R1's coccyx wound. ULP-D called RN-C into R1's room. RN-C came into R1's room and ULP-D informed RN-C R1's coccyx area had "a hole now." R1 stated "It's so sore" in regards to her buttocks and coccyx areas. ULP-D showed RN-C how deep the coccyx wound hole was by finger depth of using her index finger. ULP-D applied a large, padded dressing which covered both buttocks and coccyx areas. A sheet of paper was noted in R1's room to be orders for "wound care: leg, abdomen, foot, coccyx, buttocks, leg, foot. Prevention of pressure: abdomen. Mixed etiology: buttock and coccyx" dated September 16, 2022. ULP-D stated at the time "they aren't current orders. I looked at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 161 MAR [medication administration record] before coming in" (to R1's room). ULP-D stated directions for wound treatment to the areas on R1's left/right lower feet/legs/buttocks and coccyx were located on the MAR. ULP-D stated, "Staff do the best they can with how trained", regarding providing wound dressing changes to the above areas. ULP-D stated the wound dressing changes were to be completed daily. R1's record included the following prescriber's orders for treatments: -CPAP prescription dated October 20, 2021. -Bluestone Vista/Extended Care clinic note dated October 4, 2022, included acetic acid 0.25% irrigation solution use to irrigate the affected area once daily. Open bottle good for 24 hours, contour Next Monitor device kit use to test blood sugars "5" (five) times "QD" (every day), Jobst knee high stockings and Velcro compression wraps bilateral lower legs. -Department of Surgery, Wound and Ostomy Care note dated October 11, 2022, indicated bilateral leg and buttock wounds, here for recheck. Resides at assisted living and home care is assisting with dressings. Currently on antibiotic after presenting to ER (emergency room) over the weekend with symptoms of cellulitis. She is wearing short stretch wraps to legs today. Longstanding lymphedema bilaterally. "Left foot ulcers: will protect this foot with dressing for another week then d/c [discontinue]. Left posterior calf ulcer: apply promogran [topical wound treatment containing collagen, oxidized-regenerated cellulose and 1% silver] to the ulcer and cover with a bordered foam. Right buttock/coccyx ulcers: there are three open areas (one on right buttock, sacral area and 2 at the coccyx at the gluteal cleft. These 2 are slightly deeper). Will start Triad wound dressing [sterile	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 162	01950		

coating applied directly onto the wound] covered with a bordered foam. Venous insufficiency/lymphedema: will need ongoing compression and elevation. Does have Velcro compression garments and Jobst stockings to wear, okay to transition anytime. Today applied short stretch wraps bilaterally on the lower legs". The orders did not address dressing changes for umbilical area and left buttock.

R1's Medication Administration Record (MAR) dated October 2022, included the following:
-acetic acid 0.25 percent (%) irrigation solution - use to irrigate the affected area once daily
-dressing change with abdominal pad to bilateral legs two times a day. Wash affected area with mild soap and dry. Apply prescribed dressing to ulcer area.

R1's Service Checkoff List dated October 2022, included the following:
-skin care - resident assistant to apply lotion to lower extremities. Resident receives wound care 8 a.m. and 8 p.m. See treatment administration record (TAR) for instructions. The resident assistant will verbally report any changes to the skin such as as open areas, drainage or redness to the nurse.

R1's record lacked documented specific instructions for the delegated treatment services of wound dressing changes (left and right lower extremities, umbilical area, coccyx area and right and left buttocks), ace wraps, short stretch wraps, Velcro compression garments, Jobst stockings and CPAP.

On October 19, 2022, at 1:29 p.m. RN-C informed she started working for the licensee on August 2, 2022. RN-C stated she had no prior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 163 assisted living experience. RN-C stated, "I am learning it." RN-C stated, "I have not done anything with [R1's] wounds". On October 21, 2022, at 11:30 a.m. RN-C verified R1's record lacked documented specific instructions for the delegated treatment services of wound dressing changes, ace wraps, short stretch wraps, Velcro compression garments, Jobst stockings and CPAP. R2 R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including ostomy, compression stocking assist, and colostomy assistance. R2's service plan lacked the treatment services of nephrostomy tube (a thin catheter placed into kidney to drain urine) site/catheter bag cares and Urostomy stoma (an opening in the abdominal wall that redirects urine away from the bladder) site/catheter bag cares. On October 18, 2022, at 8:08 a.m. R2 laid in bed and was observed to have a Urostomy (right side abdomen) and nephrostomy tubes on right and left sides (kidney areas). ULP-G and ULP-I were observed to empty R2's nephrostomy catheter bags (right and left sides) and Urostomy catheter bag. ULP-G and ULP-D were observed to provide nephrostomy tube site cares to R2. ULP-G stated the dressing for the nephrostomy tube sites were to be changed daily. ULP-G removed the dressing from the left side nephrostomy tube site and cleansed around the site with an alcohol pad. ULP-G folded in half a 4 x 4 gauze pad and placed the folded gauze underneath the tube and secured the gauze with tape. ULP-D removed the dressing from right side nephrostomy tube site, cleansed around the site with acetic acid using a gauze pad, used scissors to cut a slit into a non	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 164	01950		

stick pad, placed the non-stick pad around the tube site and secured the pad with tape. ULP-D removed the dressing from around the right tube site which ULP-G had applied, cleansed around the site with the same gauze (with acetic acid on it) and applied a split non-stick dressing secured with tape around the site.

R2's record included the following prescriber's orders for treatments:
-July 26, 2022, compression socks knee high, bilateral.
-August 24, 2022, Urostomy - the patient's ordered pouching system is a two piece pouch. Pouch order Hollister 1687, accessories: skin barrier ring (120700), ostomy belt and protective seal 12037, night bag. Instructions were given to patient who verbalized understanding, given to caregiver who verbalized understanding. In case of bleeding hold pressure for 5-10 minutes. If does not stop seek emergency care.
-September 20, 2022, hospital After Visit Summary indicated dates September 14, 2022, to September 20, 2022, and diagnosis infection urinary tract. Since September 15, 2022, interval placement of bilateral percutaneous nephrostomy tubes. Nephrostomy tubes to be kept to gravity; cleanse around tube sites every other day with soap and water, dry well and place split gauze around the tube insertion site, cover with dry gauze, change every other day or sooner if soilage of the gauze is noted. Urostomy - go back to usual pouches, skin care and pouch changes.

R2's MAR dated October 2022, included the following:
-acetic acid 0.25 percent (%) irrigation solution - use twice daily for wound cleansing

R2's Service Checkoff List dated October, 2022,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 165 included the following: -colostomy assistance - resident has colostomy, assist with changing every other day and as needed. Adhesive wipe to remove left over adhesive on skin. Remove old bag. Spray adhesive spray on new appliance and pace around colostomy. Snap bag onto appliance. Resident can walk you through it. Resident assistant will report any skin changes around the colostomy site or problems with colostomy equipment to nurse. -compression stockings - resident assistant will apply compression stockings in the morning and remove at bedtime. The RA will verbally report any open areas or redness on the skin that does not disappear to the nurse. -ostomy a.m., p.m., noc (night) - empty nephrostomy drainage bags if needed and clean around the site. The resident assistant will report any skin changes around the ostomy site or problems with equipment to the nurse. The stoma will be pink or red, moist, and a little shiny. Contact nurse "ASAP" (as soon as possible) if any issues or concerns. -Ostomy as needed (PRN) has Urostomy, assist with changing every other day and as needed. Adhesive wipe to remove left over adhesive on skin. Remove old bag. Spray adhesive spray on new appliance and pace around Urostomy. Snap bag onto appliance. Resident can walk you through it. Resident assistant will report any skin changes around the ostomy site or problems with colostomy equipment to nurse. The stoma will be pink or red, moist, and a little shiny. Contact nurse ASAP if any issues or concerns. R2's record lacked clear documented specific instructions for the delegated treatment services of nephrostomy tube site/catheter bag cares and Urostomy stoma site/catheter bag cares.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 166 ULP TRAINING AND DEMONSTRATED COMPETENCY ULP-G had a hire date of September 20, 2022. ULP-G's record lacked training and demonstrated competency for providing the treatment services of R1's wound dressing changes, short stretch wraps and Velcro compression garments. ULP-G's record lacked training and demonstrated competency for providing the treatment services of R2's nephrostomy tube site/catheter bag cares and Urostomy stoma site/catheter bag cares. ULP-H had a hire date of August 17, 2021. ULP-H's record lacked training and demonstrated competency for providing the treatment services of R1's wound dressing changes, short stretch wraps and Velcro compression garments. ULP-H's record lacked training and demonstrated competency for providing the treatment services of R2's nephrostomy tube site/catheter bag cares and Urostomy stoma site/catheter bag cares. ULP-I had a hire date of December 28, 2021. ULP-I's record lacked training and demonstrated competency for providing the treatment services of R1's wound dressing changes, short stretch straps and Velcro compression garments. ULP-I's record lacked training and demonstrated competency for providing the treatment services of R2's nephrostomy tube site/catheter bag cares and Urostomy stoma site/catheter bag cares. On October 21, 2022, at 12:48 p.m. RN-C verified R2's record lacked documented specific instructions for the delegated treatment services of nephrostomy tube site/catheter bag cares and Urostomy stoma site/catheter bag cares. On October 21, 2022, at 2:47 p.m. RN-C verified	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01950	Continued From page 167 ULP-G, ULP-H and ULP-I lacked training and demonstrated competency for providing the treatment services of R1's wound dressing changes, short stretch wraps, Velcro compression garments and R2's nephrostomy tube site/catheter bag cares and Urostomy stoma site/catheter bag cares. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated unlicensed personal that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN. Medications, treatment and therapy always need to be administered according to the "6 Rights". The RN may delegate to unlicensed personnel the task of providing assistance with self-administration of medications or delegate administration of medications, treatment and therapy if the ULP has satisfied the training requirements of demonstrated ability to completely follow the procedures, the RN has developed written, specific instruction for each resident and the RN has documented that the ULP have been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 168 signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented for two of three residents (R1, R2). 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: R1 R1's Service Plan Agreement signature date August 2, 2022, indicated R1 received services including skin care (the resident assistant will verbally report any changes to the skin such as open areas, drainage or redness to the nurse. R1's service plan lacked the treatment services of blood sugar checks, wound dressing changes, ace wraps (compression wraps used to reduce swelling), short stretch wraps (low elasticity bandages used to reduce swelling), Velcro compression garments (compression wrap used	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 169 to reduce swelling), Jobst stockings (used to reduce swelling) and CPAP use (a medical device used to obtain continuous positive airway pressure). On October 18, 2022, at 8:43 a.m. R1 stated a "wound nurse" comes to the facility "two times a week on Monday and Friday" to provide "wound cares." R1 stated she had "cellulitis" in both legs, and she had two open areas on the right leg and one open area on the left leg. R1 stated she had "one big and one small joined" wound on her bottom. On October 19, 2022, at 8:43 a.m. unlicensed personnel (ULP)-D was observed to provide wound dressing changes to R1's left and right lower extremities, umbilical area, coccyx area and right and left buttocks. ULP-D removed ace wrap and wound dressing from R1's left lower leg/foot. R1's left foot was observed to have an open area on the side of the little toe and a closed black colored area on the side of great toe. ULP-D cleansed R1's right lower leg/foot with acetic acid (used for the treatment of infections of skin), taped two abdominal (ABD) pads (absorbent pad) together around R1's lower leg and wrapped gauze cling wrap around lower left foot/leg. R1 stated staff had bumped her toe. ULP-D removed two ace wraps and wound dressing from R1's right lower leg/foot. R1's right foot was observed to have an open area on the side of the little toe and R1's upper outer right side lower leg had an intact blister. Scant purple colored bruising was noted on top of R1's right foot and top end of R1's great toe. ULP-D stated she noticed the blistered area last Friday. ULP-D removed a Mepilex dressing (antimicrobial foam dressing) from the outer side of R1's foot. The skin was intact underneath the dressing. ULP-D stated about two	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 170	01960		

weeks ago the skin area under the Mepilex on R1's outer right side of foot was blistered and opened. ULP-D also stated R1 had lymphedema. ULP-D cleansed R1's lower right leg/foot with acetic acid, applied a Mepilex dressing to the right outer blister on R1's upper lower leg and outer side of R1's right foot, taped three smaller ABD pads together around R1's lower leg and wrapped gauze cling wrap around lower right foot/leg. ULP-D applied one ace wrap spirally around to R1's left and right lower foot/leg. ULP-D asked R1 if she wanted her to change the dressing to her "belly button" area. ULP-D removed Mepilex dressing from the area. The skin was intact. ULP-D cleansed the skin with acetic acid and applied a Mepilex dressing. ULP-D had R1 roll over in bed. A foam white pad dressing was in place on R1's right buttock and left buttock. ULP-D removed the white foam pads from R1's right and left buttocks. The skin underneath the foam pads was open. R1's coccyx area had no dressing in place. ULP-D asked R1 if the Mepilex dressing fell off the coccyx area. ULP-D stated the open area on R1's coccyx "has gotten worse." ULP-D cleansed the coccyx area with a dry disposable pad cloth. ULP-D stated "I can put my finger in the hole" while placing tip of index finger into the area. ULP-D applied thick moisture barrier paste to R1's coccyx wound. ULP-D called registered nurse RN-C into R1's room. RN-C came into R1's room and ULP-D informed RN-C R1's coccyx area had "a hole now." ULP-D showed RN-C how deep the coccyx wound hole was by finger depth of using her index finger. ULP-D applied a large, padded dressing which covered both buttocks and coccyx areas. ULP-D showed the surveyor two previous open areas on R1's right thigh and one on the back of the left thigh which she stated were present when R1 was admitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 171 but were now healed. A sheet of paper was noted to be in R1's room to be orders for "wound care: leg, abdomen, foot, coccyx, buttocks, leg, foot. Prevention of pressure: abdomen. Mixed etiology: buttock and coccyx" dated September 16, 2022. ULP-D stated "they aren't current orders. I looked at the MAR [medication administration record] before coming in" (to R1's room). ULP-D stated upon admission R1 had the open areas to the "thigh" areas and "smaller one top back buttocks" (higher up on coccyx). ULP-D stated the umbilical area and leg areas were ongoing on and off. ULP-D stated the open areas on R1's right/left buttocks, coccyx and toe areas were all new after admission and R1 had no cellulitis to lower extremities when she was admitted. ULP-D stated directions for wound treatment to the areas on R1's left/right lower feet/legs/buttocks and coccyx were located on the MAR. ULP-D stated, "Staff do the best they can with how trained," regarding providing wound dressing changes to the above areas. ULP-D stated the wound dressing changes were to be completed daily. R1's record included the following prescriber's orders for treatments: -CPAP prescription dated October 20, 2021. -Department of Surgery, Wound and Ostomy Care note dated October 11, 2022, indicated bilateral leg and buttock wounds, here for recheck. Resides at assisted living and home care is assisting with dressings. Currently on antibiotic after presenting to ER (emergency room) over the weekend with symptoms of cellulitis. She is wearing short stretch wraps to legs today. Longstanding lymphedema bilaterally. "Left foot ulcers: will protect this foot with dressing for another week then d/c [discontinue]. Left posterior calf ulcer: apply promogran [topical wound treatment containing collagen,	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 172	01960		

oxidized-regenerated cellulose and 1% silver] to the ulcer and cover with a bordered foam. Right buttock/coccyx ulcers: there are three open areas (one on right buttock, sacral area and 2 at the coccyx at the gluteal cleft. These 2 are slightly deeper). Will start Triad wound dressing [sterile coating applied directly onto the wound] covered with a bordered foam. Venous insufficiency/lymphedema: will need ongoing compression and elevation. Does have Velcro compression garments and Jobst stockings to wear, okay to transition anytime. Today applied short stretch wraps bilaterally on the lower legs". The orders did not address dressing changes for umbilical area and left buttock.

R1's Medication Administration Record (MAR) dated October 2022, included the following:
-acetic acid 0.25 percent (%) irrigation solution - use to irrigate the affected area once daily
-dressing change with abdominal pad to bilateral legs two times a day. Wash affected area with mild soap and dry. Apply prescribed dressing to ulcer area.

R1's Service Checkoff List dated October 2022, included the following:
-skin care - resident assistant to apply lotion to lower extremities. Resident receives wound care 8 a.m. and 8 p.m. See treatment administration record (TAR) for instructions. The resident assistant will verbally report any changes to the skin such as as open areas, drainage or redness to the nurse. The licensee lacked utilization of TAR as indicated.

R1's record lacked documentation from the provision of wound dressing changes (umbilical area, coccyx area and right and left buttocks), ace wraps, short stretch wraps, Velcro

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 173 compression garments, Jobst stockings and CPAP. On October 19, 2022, at 1:29 p.m. RN-C informed she started working for the licensee on August 2, 2022. RN-C stated she had no prior assisted living experience. RN-C stated, "I am learning it." RN-C stated, "I have not done anything with [R1's] wounds". On October 20, 2022, at 1:08 p.m. ULP-D stated R1's Department of Surgery, Wound and Ostomy Care note dated October 11, 2022, were the current prescriber's orders for R1's wounds. On October 21, 2022, at 11:30 a.m. RN-C verified R1's record lacked documentation for the provision of wound dressing changes (umbilical area, coccyx area and right and left buttocks), ace wraps, short stretch wraps, Velcro compression garments, Jobst stockings and CPAP. R2 R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including ostomy, compression stocking assist, and colostomy assistance. R2's service plan lacked the treatment services of nephrostomy tube (a thin catheter placed into kidney to drain urine) site/catheter bag cares and Urostomy stoma (an opening in the abdominal wall that redirects urine away from the bladder) site/catheter bag cares. On October 18, 2022, at 8:08 a.m. R2 laid in bed and was observed to have a Urostomy (right side abdomen) and nephrostomy tubes on right and left sides (kidney areas). ULP-G and ULP-I were observed to empty R2's nephrostomy catheter bags (right and left sides) and Urostomy catheter	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 174 bag. ULP-G and ULP-D were observed to provide nephrostomy tube site cares to R2. ULP-G stated the dressing for the nephrostomy tube sites were to be changed daily. ULP-G removed the dressing from the left side nephrostomy tube site and cleansed around the site with an alcohol pad. ULP-G folded in half a 4 x 4 gauze pad and placed the folded gauze underneath the tube and secured the gauze with tape. ULP-D removed the dressing from right side nephrostomy tube site, cleansed around the site with acetic acid using a gauze pad, used scissors to cut a slit into a non-stick pad, placed the non-stick pad around the tube site and secured the pad with tape. ULP-D removed the dressing from around the right tube site which ULP-G had applied, cleansed around the site with the same gauze (with acetic acid on it) and applied a split non-stick dressing secured with tape around the site. R2's record included the following prescriber's orders for treatments: -July 26, 2022, compression socks knee high, bilateral. -August 24, 2022, Urostomy - the patient's ordered pouching system is a two piece pouch. Pouch order Hollister 1687, accessories: skin barrier ring (120700), ostomy belt and protective seal 12037, night bag. Instructions were given to patient who verbalized understanding, given to caregiver who verbalized understanding. In case of bleeding hold pressure for 5-10 minutes. If does not stop seek emergency care. -September 20, 2022, hospital After Visit Summary indicated dates September 14, 2022, to September 20, 2022, and diagnosis infection urinary tract. Since September 15, 2022, interval placement of bilateral percutaneous nephrostomy tubes. Nephrostomy tubes to be kept to gravity;	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 175 cleanse around tube sites every other day with soap and water, dry well and place split gauze around the tube insertion site, cover with dry gauze, change every other day or sooner if soilage of the gauze is noted. Urostomy - go back to usual pouches, skin care and pouch changes. R2's MAR dated October 2022, included the following: -acetic acid 0.25 percent (%) irrigation solution - use twice daily for wound cleansing (did not indicate the location of wounds) R2's Service Checkoff List dated October, 2022, included the following: -compression stockings a.m. - resident assistant will apply compression stockings in the morning and remove at bedtime. The RA will verbally report any open areas or redness on the skin that does not disappear to the nurse. -ostomy a.m., p.m., noc (night) - empty nephrostomy drainage bags if needed and clean around the site. The resident assistant will report any skin changes around the ostomy site or problems with equipment to the nurse. The stoma will be pink or red, moist, and a little shiny. Contact nurse "ASAP" (as soon as possible) if any issues or concerns. -Ostomy as needed (PRN) has Urostomy, assist with changing every other day and as needed. Adhesive wipe to remove left over adhesive on skin. Remove old bag. Spray adhesive spray on new appliance and pace around Urostomy. Snap bag onto appliance. Resident can walk you through it. Resident assistant will report any skin changes around the ostomy site or problems with colostomy equipment to nurse. The stoma will be pink or red, moist, and a little shiny. Contact nurse ASAP if any issues or concerns.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01960	Continued From page 176 R2's record lacked documentation for the provision of services for removal of compression stockings and consistent documentation for the provision of nephrostomy and Urostomy tube site/catheter cares. On October 21, 2022, at 12:48 p.m. RN-C verified the licensee was providing treatment services for R2. RN-C verified R2's record lacked documentation for the provision of services for removal of compression stockings and consistent documentation for the provision of nephrostomy and Urostomy tube site/catheter cares. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated August 1, 2021, indicated staff would document each task immediately after tasks has been performed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 177 Based on observation, interview, and record review the licensee failed to ensure clear prescriber's orders for treatment or therapy for three of three residents (R1, R2, R5). 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: R1 R1's Service Plan Agreement signed August 2, 2022, indicated R1 received services including skin care (the resident assistant will verbally report any changes to the skin such as open areas, drainage or redness to the nurse. The nurse will review the results at least every 90 days to update the prescriber as indicated). R1's service plan lacked the treatment services of blood sugar checks, wound dressing changes, ace wraps (compression wraps used to reduce swelling), short stretch wraps (low elasticity bandages used to reduce swelling), Velcro compression garments (compression wrap used to reduce swelling), Jobst stockings (used to reduce swelling) and CPAP use (a medical device used to obtain continuous positive airway pressure). On October 18, 2022, at 8:43 a.m. R1 stated a "wound nurse" comes to the facility "two times a week on Monday and Friday" to provide "wound	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 178	01970		

cares." R1 stated she had "cellulitis" in both legs, and she had two open areas on the right leg and one open area on the left leg. R1 stated she had "one big and one small joined" wound on her bottom.

On October 19, 2022, at 8:43 a.m. unlicensed personnel (ULP)-D was observed to check R1's blood sugar and provide wound dressing changes to R1's left and right lower extremities, umbilical area, coccyx area and right and left buttocks. ULP-D removed ace wrap and wound dressing from R1's left lower leg/foot. R1's left foot was observed to have an open area on the side of the little toe and a closed black colored area on the side of great toe. ULP-D cleansed R1's right lower leg/foot with acetic acid (used for the treatment of infections of skin), taped two abdominal (ABD) pads (absorbent pad) together around R1's lower leg and wrapped gauze cling wrap around lower left foot/leg. R1 stated staff had bumped her toe. ULP-D removed two ace wraps and wound dressing from R1's right lower leg/foot. R1's right foot was observed to have an open area on the side of the little toe and R1's upper outer right side lower leg had an intact blister. Scant purple colored bruising was noted on top of R1's right foot and top end of R1's great toe. ULP-D stated she noticed the blistered area last Friday. ULP-D removed a Mepilex dressing (antimicrobial foam dressing) from the outer side of R1's foot. The skin was intact underneath the dressing. ULP-D stated about two weeks ago the skin area under the Mepilex on R1's outer right side of foot was blistered and opened. ULP-D stated R1 had lymphedema. ULP-D cleansed R1's lower right leg/foot with acetic acid, applied a Mepilex dressing to the right outer blister on R1's upper lower leg and outer side of R1's right foot, taped three smaller ABD pads together around

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 179 R1's lower leg and wrapped gauze cling wrap around lower right foot/leg. ULP-D applied one ace wrap spirally around to R1's left and right lower foot/leg. ULP-D asked R1 if she wanted her to change the dressing to her "belly button" area. ULP-D removed Mepilex dressing from the area. The skin was intact. ULP-D cleansed the skin with acetic acid and applied a Mepilex dressing. ULP-D had R1 roll over in bed. A foam white pad dressing was in place on R1's right buttock and left buttock. ULP-D removed the white foam pads from R1's right and left buttocks. The skin underneath the foam pads was open. R1's coccyx area had no dressing in place. ULP-D asked R1 if the Mepilex dressing fell off the coccyx area. ULP-D stated the open area on R1's coccyx "has gotten worse". ULP-D cleansed the coccyx area with a dry disposable pad cloth. ULP-D stated "I can put my finger in hole" while placing tip of index finger into the area. ULP-D applied thick moisture barrier paste to R1's coccyx wound. ULP-D called registered nurse RN-C into R1's room. RN-C came into R1's room and ULP-D informed RN-C R1's coccyx area had "a hole now." R1 stated regarding her buttocks and coccyx areas "It's so sore." ULP-D stated to RN-C "I put my finger in there" referring to the wound on R1's coccyx. ULP-D showed RN-C how deep the coccyx wound hole was by finger depth of using her index finger. ULP-D applied a large, padded dressing which covered both buttocks and coccyx areas. ULP-D showed surveyor two previous open areas on R1's right thigh and one on back left thigh which she stated were present when R1 was admitted but were now healed. A sheet of paper was noted to be in R1's room to be orders for "wound care: leg, abdomen, foot, coccyx, buttocks, leg, foot. Prevention of pressure: abdomen. Mixed etiology: buttock and coccyx" dated September 16, 2022. ULP-D stated	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 180 at the time "they aren't current orders. I looked at the MAR [medication administration record] before coming in" (to R1's room). ULP-D stated upon admission R1 had the open areas to the "thigh" areas and "smaller one top back buttocks" (higher up on coccyx). ULP-D stated the umbilical area and leg areas were ongoing on and off. ULP-D stated the open areas on R1's right/left buttocks, coccyx and toe areas were all new after admission and R1 had no cellulitis to lower extremities when she was admitted. ULP-D stated directions for wound treatment to the areas on R1's left/right lower feet/legs/buttocks and coccyx were located on the MAR. ULP-D stated, "Staff do the best they can with how trained", regarding providing wound dressing changes to the above areas. ULP-D stated the wound dressing changes were to be completed daily. R1's Medication Administration Record (MAR) dated October 2022, included the following: -acetic acid 0.25 percent (%) irrigation solution - use to irrigate the affected area once daily -dressing change with abdominal pad to bilateral legs two times a day. Wash affected area with mild soap and dry. Apply prescribed dressing to ulcer area. R1's Service Checkoff List dated October 2022, included the following: -skin care - resident assistant to apply lotion to lower extremities. Resident receives wound care 8 a.m. and 8 p.m. See treatment administration record (TAR) for instructions. The resident assistant will verbally report any changes to the skin such as as open areas, drainage or redness to the nurse. R1's record included the following prescriber's orders for treatments:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 181 -CPAP prescription dated October 20, 2021. -Department of Surgery, Wound and Ostomy Care note dated October 11, 2022, indicated bilateral leg and buttock wounds, here for recheck. Resides at assisted living and home care is assisting with dressings. Currently on antibiotic after presenting to ER (emergency room) over the weekend with symptoms of cellulitis. She is wearing short stretch wraps to legs today. Longstanding lymphedema bilaterally. "Left foot ulcers: will protect this foot with dressing for another week then d/c [discontinue]. Left posterior calf ulcer: apply promogran [topical wound treatment containing collagen, oxidized-regenerated cellulose and 1% silver] to the ulcer and cover with a bordered foam. Right buttock/coccyx ulcers: there are three open areas (one on right buttock, sacral area and 2 at the coccyx at the gluteal cleft. These 2 are slightly deeper). Will start Triad wound dressing [sterile coating applied directly onto the wound] covered with a bordered foam. Venous insufficiency/lymphedema: will need ongoing compression and elevation. Does have Velcro compression garments and Jobst stockings to wear, okay to transition anytime. Today applied short stretch wraps bilaterally on the lower legs". The orders did not address dressing changes for umbilical area and left buttock. R1's record lacked current prescriber orders for CPAP, clear prescriber's orders for wound dressing changes (left and right lower extremities, umbilical area, coccyx area and right and left buttocks), ace wraps, short stretch wraps, Velcro compression garments and Jobst stockings. On October 19, 2022, at 1:29 p.m. RN-C informed she started working for the licensee on August 2, 2022. RN-C stated she had no prior	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 182	01970		

assisted living experience. RN-C stated, "I am learning it." RN-C stated, "I have not done anything with [R1's] wounds."

On October 20, 2022, at 1:08 p.m. ULP-D stated R1 used a CPAP. ULP-D stated R1's prescriber's order for her CPAP was expired. ULP-D stated R1's Department of Surgery, Wound and Ostomy Care note dated October 11, 2022, were the current prescriber's orders for R1's wounds.

On October 21, 2022, at 11:30 a.m. RN-C verified R1's record lacked clear prescriber's orders for wound dressing changes (left and right lower extremities, umbilical area, coccyx area and right and left buttocks), ace wraps, short stretch wraps, Velcro compression garments and Jobst stockings.

R2
R2's Service Plan Agreement dated October 18, 2022, indicated R2 received services including ostomy, compression stocking assist, and colostomy assistance. R2's service plan lacked the treatment services of nephrostomy tube (a thin catheter placed into kidney to drain urine) site/catheter bag cares and Urostomy stoma (an opening in the abdominal wall that redirects urine away from the bladder) site/catheter bag cares.

On October 18, 2022, at 8:08 a.m. R2 laid in bed and was observed to have a Urostomy (right side abdomen) and nephrostomy tubes on right and left sides (kidney areas). ULP-G and ULP-I were observed to empty R2's nephrostomy catheter bags (right and left sides) and Urostomy catheter bag. ULP-G and ULP-D were observed to provide nephrostomy tube site cares to R2. ULP-G stated the dressing for the nephrostomy tube sites were to be changed daily. ULP-G removed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 183 dressing from the left side nephrostomy tube site and cleansed around the site with an alcohol pad. ULP-G folded in half a 4 x 4 gauze pad and placed the folded gauze underneath the tube and secured the gauze with tape. ULP-D removed the dressing from right side nephrostomy tube site, cleansed around the site with acetic acid using a gauze pad, used scissors to cut a slit into a non-stick pad, placed the non-stick pad around the tube site and secured the pad with tape. ULP-D removed the dressing from around the right tube site which ULP-G had applied, cleansed around the site with the same gauze (with acetic acid on it) and applied a split non-stick dressing secured with tape around the site. R2's MAR dated October 2022, included the following: -acetic acid 0.25 percent (%) irrigation solution - use twice daily for wound cleansing R2's Service Checkoff List dated October, 2022, included the following: -compression stockings - resident assistant will apply compression stockings in the morning and remove at bedtime. The RA will verbally report any open areas or redness on the skin that does not disappear to the nurse. -ostomy - empty nephrostomy drainage bags if needed and clean around the site. The resident assistant will report any skin changes around the ostomy site or problems with equipment to the nurse. The stoma will be pink or red, moist, and a little shiny. Contact nurse "ASAP" (as soon as possible) if any issues or concerns. -Ostomy as needed (PRN) has Urostomy, assist with changing every other day and as needed. Adhesive wipe to remove left over adhesive on skin. Remove old bag. Spray adhesive spray on	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 184	01970		

new appliance and pace around Urostomy. Snap bag onto appliance. Resident can walk you through it. Resident assistant will report any skin changes around the ostomy site or problems with colostomy equipment to nurse. The stoma will be pink or red, moist, and a little shiny. Contact nurse ASAP if any issues or concerns.

R2's record included the following prescriber's orders for treatments:
-July 26, 2022, compression socks knee high, bilateral.
-August 24, 2022, Urostomy - the patient's ordered pouching system is a two piece pouch. Pouch order Hollister 1687, accessories: skin barrier ring (120700), ostomy belt and protective seal 12037, night bag. Instructions were given to patient who verbalized understanding, given to caregiver who verbalized understanding. In case of bleeding hold pressure for 5-10 minutes. If does not stop seek emergency care.
-September 20, 2022, hospital After Visit Summary indicated dates September 14, 2022, to September 20, 2022, and diagnosis infection urinary tract. Since September 15, 2022, interval placement of bilateral percutaneous nephrostomy tubes. Nephrostomy tubes to be kept to gravity; cleanse around tube sites every other day with soap and water, dry well and place split gauze around the tube insertion site, cover with dry gauze, change every other day or sooner if soilage of the gauze is noted. Urostomy - go back to usual pouches, skin care and pouch changes.

R2's record lacked clear prescriber orders for compression stockings (frequency) and Urostomy site and nephrostomy/Urostomy catheter bag changes.

On October 21, 2022, at 12:48 p.m. RN-C verified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 185 R2's record lacked clear prescriber orders for compression stockings (frequency) and Urostomy site and nephrostomy/Urostomy catheter bag changes. R5 R5's diagnoses included lupus anticoagulation syndrome (an autoimmune disorder that causes blood clots to form in various parts of the body), thrombosis (blood clot) of deep veins of unspecified lower extremity and history of pulmonary embolism (blood clot in the lung) with long term anticoagulation (blood thinning) management. R5's service plan dated August 11, 2022, indicated R5 received services to include TED (thromboembolism deterrent) assistance and wound care. R5's Medication Administration Record (MAR) dated October 2022, included wound treatment of Mepilex dressing with border placed every three days to her intergluteal folds (coccyx area). On October 18, 2022, at approximately 8:45 a.m. ULP-E was observed to provide R5's coccyx wound check. R5 stated her TED stockings had already been placed on both lower extremities by another staff earlier that morning. R5's provider communication document dated September 27, 2022, indicated "Will DC (discontinue) Mepilex dressing." On October 18, 2022, at approximately 5:05 p.m. R5's daughter indicated the wound had healed and she believed the provider wrote an order "a few weeks ago," to discontinue the mepilex dressing. R5's daughter stated the wound had	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
01970	Continued From page 186 improved with use of an incontinence brief or a pad that minimized the moisture to the area. On October 19, 2022, at approximately 3:00 p.m. RN-C stated she had just been made aware of the order to discontinue wound care today (October 19, 2022), and verified R5 lacked an order for TED stockings and had a call into the provider to obtain an TED stocking order for R5's record. The licensee's Medication and Treatment Orders policy dated August 2021, indicated the RN was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards with bedrails/side rails for three of four residents	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
02310	Continued From page 187 (R1, R2, R3). This resulted in an immediate correction order on October 20, 2022, at approximately 9:58 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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: R1 R1's Service Plan Agreement dated August 2, 2022, noted services included medication administration/management, bathing/dressing/skin care/toileting assistance, laundry, housekeeping/linen changes and meals. On October 18, at 10:27 a.m. R1's bed was observed to have one half side rail in the upright position on the left and right upper halves of the bed. R1 stated she used the siderails for "safety and moving in bed". R1's record identified Bedrail Assessments dated July 26, 2022, July 29, 2022, and October 18, 2022. The assessments indicated bedrail/grab bar/physical device precautions (the risk vs. benefits of rail use) have been discussed with resident, "FDA" (Food and Drug Administration) bedrail brochure was provided on admission, "left 1/2 rail, right 1/2 rail, no rail openings are greater than 4.75 inches, there is no open space between the bottom of the rail support and the mattress	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
02310	Continued From page 188	02310		

greater than 4.75 inches, there are no gaps between rail and mattress, there are no rail openings greater than 2.375 inches for gap between mattress and lowermost portion of the rail, "no" does not have split rails, "no" gap between end of mattress and head board" and the bedrail was connected via bolts to the bed frame. The assessment did not address if R1 safely utilized the bed rails.

On October 20, 2022, at 9:38 a.m. R1's bed was observed and measured with registered nurse (RN)-C to have one half side rail in the upright position on the left and right upper halves of the bed. The bed rail measurements for zone 1 were found to be within 3.9 inches for spaces, zone 2 no space, zone 3 within 1 inch, zone 4 no space. The bedrails were securely attached to the bed.

R1's record lacked documented evidence of R1's ability to safely utilize the bedrails and bed rail measurements for zones as noted above completed with RN-C for zone 1, zone 3.

R2
R2's Service Plan Agreement dated October 18, 2022, noted services included medication administration/management, bathing/dressing/toileting, ostomy care, colostomy assistance, pendant check, meals, compression stocking assistance, laundry, housekeeping and bed mobility assistance.

On October 18, at 8:08 a.m. R2's bed was observed to have one half side rail in the upright position on the left and right upper halves of the bed. R2 was observed to hold onto the bedrails when rolling over in bed during assistance of being provided dressing and hygiene cares by unlicensed personnel (ULP)-D, ULP-G and ULP-I.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
02310	Continued From page 189 On October 20, 2022, at 9:30 a.m. R2's bed was observed and measured with RN-C to have one half side rail in the upright position on the left upper half of the bed and the right one half siderail was removed from the bed and was placed between the headboard of the bed and the wall in R2's bedroom. RN-C verified the right one half rail had been on R2's bed and indicated it may have been removed last evening when R2 was sent by ambulance to the hospital. The bed rail measurements for zone 1 were found to be within 3.75 inches for spaces, zone 2 no space, zone 3 no space, zone 4 no space. The left side bed rail was securely attached to the bed. R2's record lacked evidence of assessment for use of the siderails, measurements according to Food and Drug Administration (FDA) guidelines and lacked evidence the risks and benefits of side rail use was explained. R3 R3's Service Plan Agreement dated August 2, 2022, noted services included meals, temperature check, oximeter reading (oxygen level), housekeeping and laundry. On October 18, at 9:49 a.m. ULP-J was observed to administer medications to R3. R3's bed was observed to have one half side rail in the upright position on the left and right upper halves of the bed. The bedrails were securely attached to the bed. On October 20, 2022, at 9:44 a.m. R3's bed was observed and measured with RN-C to have one half side rail in the upright position on the left and right upper halves of the bed. The bed rail measurements for zone 1 were found to be within	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
02310	Continued From page 190 3.75 inches for spaces, zone 2 no space, zone 3 no space, zone 4 no space. The bedrails were securely attached to the bed. R3's record lacked documented evidence of assessment for use of the siderails, measurements according to Food and Drug Administration (FDA) guidelines and lacked evidence the risks and benefits of side rail use was explained. On October 20, 2022, at 8:46 a.m. RN-C stated for R1's assessment dated October 18, 2022, she had not measured R1's bed rails and verified the assessment did not address R1's ability for safely using the bed rails. RN-C also stated R1's assessments dated July 26, 2022, and July 29, 2022, were completed by prior staff; therefore, she was not sure if measurements were completed or where the measurements would be documented other than on the assessment. RN-C verified R2 and R3's records had no documented assessment for side rail use, including measurements of the siderails and risk and benefits explained. The Food and Drug Administration (FDA) guidelines titled Recommendations for Health Care Providers about Bed Rails, dated July 9, 2018, indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bed rails, mattresses, and bed frames are interchangeable; check the manufacturer ' s	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
02310	Continued From page 191	02310		

instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer ' s recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress.

The FDA identifies vulnerable patients as those "who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement or who get out of bed and walk unsafely without assistance." These patients most often have been frail, elderly, or confused. FDA guidelines titled Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 2006, identified key body parts at risk for life-threatening entrapment of the head, neck, and chest in the seven zones of a hospital bed system, focusing on the most common zones for risk of entrapment - zones 1-4.

Zone 1 - within the rail is any open space with the perimeter of the rail. Recommended space be less than 4 ¾ inches representing head breadth.

Zone 2 - under the rail, between the rail supports or next to a single rail support. This space is the gap under the rail between a mattress

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
02310	Continued From page 192	02310		

compressed by the weight of a patient's head and the bottom edge of the rail at the location between the rail supports or next to a single rail support. Recommended space limit for entrapment in this space is less than 4 ¾ inches.

Zone 3 - between the rail and the mattress. The space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment. Recommended space between the area between the inside surface of the rail and compressed mattress should be of less than 4 ¾ inches.

Zone 4 - under the rail at the ends of the rail. This space poses a risk for entrapment of a patient's neck. In this space, a gap forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. Recommended dimension for this zone measure both less than 60 mm in size and greater than 60 degrees in angle.

The licensee's Assessing the Safety of Side Rails policy dated July 23, 2022, indicated the RN would complete a device assessment at the time of move in, upon hospital return, change in condition, and/or upon discovery of a rail. The director of health services or designee would review the risk and benefits of the device use and potential device alternatives with the resident and/or responsible party. For hospital bed the device would be installed per FDA guidelines. Documentation would be entered in the resident's record to include: results of assessment, discussion with resident/responsible party regarding risks and benefits and alternatives considered/recommended, decision made/outcome of discussion. Physical devices

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
02310	Continued From page 193 would be assessed for safety during each re-assessment. The policy further referenced the FDA's 2006 recommended dimensional measurements zones 1-4 measurements and for zones 5-7 the FDA "has not established recommended maximum dimensions". No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On October 21, 2022, at 8:24 a.m. the immediacy was removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (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	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
03000	Continued From page 194 in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the 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) a significant medication error for one of one resident (R9). This practice resulted in a level two violation (a	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
03000	Continued From page 195	03000		

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:

R9's Service Plan Agreement unsigned, included medication setup and administration.

R9's clinic note dated May 17, 2022, indicated results/data for anticoagulation management on May 12, 2022, for INR (international normalized ratio/lab calculation based on prothrombin test results; a test measuring how long it takes a blood clot to form in a blood sample) was "2.2" and "anticoag [anticoagulation] dosing goal INR" was "2.0 - 3.0". Continue warfarin (used to prevent blood clots) 8 milligrams (mg) daily.

R9's Medication Incident Report dated June 2, 2022, indicated "resident was to be given a 6 mg tablet and a 2 mg tablet to equal 8 mg total. Medication was to be held on 5/26/22 [May 26, 2022] and the INR was to be redrawn. New order was to be started upon new dosage obtained from pharmacy. Medication was not given on 5/28/22-5/30/22 [May 28, 2022, through May 30, 2022]. Resident assistant working on 5/31/22 [May 31, 2022] administered medication correctly upon finding medication in medication room. Resident went to prescheduled clinic visit on 6/2/22 [June 2, 2022] for INR recheck and it was noted to be '1.2'. Clinic staff contacted nurse to discuss results and it was at that time determined that the resident had indeed missed 3 scheduled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30703	A. BUILDING: _____ B. WING _____	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRE MONARCH MEADOWS	2135 LOR RAY DRIVE NORTH MANKATO, MN 56003

(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
03000	Continued From page 196 doses. Resident remained asymptomatic throughout duration of incident. Medication dose has been adjusted to address current concerns." R9's Medication Administration Record dated May 2022, identified the licensee's staff were administering medications to R9. On October 21, 2022, at 1:44 p.m. registered nurse (RN)-C stated regarding R9 not receiving coumadin for three doses, "Yes, definitely a significant med error". RN-C stated she would "look" to see if the incident was reported to MAARC; however, no further information was provided. The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated any staff person who witnesses or suspects maltreatment of a vulnerable adult would report the incident immediately to their "LALD" (licensed assisted living director), director of health services or designee and that person would complete and incident report. If the incident appears to be suspected abuse, neglect or financial exploitation, the LALD, director of health services or designee would immediately report tot he "CEP" (common entry point). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/17/22*
Time: 11:00:00
Report: 1020221142

Food and Beverage Establishment Inspection Report

Location:
Vista Praire Monarch Meadows
2135 Lor Ray Drive
North Mankato, MN56003
Nicollet County, 52

Establishment Info:
ID #: 0038578
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073440059
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: DISHWASHER - KITCHEN A
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET - KITCHEN A
Violation Issued: No

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: DISHWASHER - KITCHEN B
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, KITCHEN A
Violation Issued: No

Process/Item: Hot Holding
Temperature: 186 Degrees Fahrenheit - Location: GREEN BEANS - STEAM TABLE, KITCHEN A
Violation Issued: No

Process/Item: Hot Holding
Temperature: 178 Degrees Fahrenheit - Location: SOUP - STEAM TABLE, KITCHEN A
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: BUTTER - UPRIGHT COOLER NEAR DISHWASHING AREA, KITCHEN A
Violation Issued: No

Type: Full
Date: *10/17/22*
Time: 11:00:00
Report: 1020221142
Vista Praire Monarch Meadows

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SOUR CREAM - UPRIGHT COOLER #1, KITCHEN A

Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: PASTA SALAD - UPRIGHT COOLER, KITCHEN B
Violation Issued: No

Process/Item: Hot Holding
Temperature: 158 Degrees Fahrenheit - Location: GREAN BEANS - STEAM TABLE, KITCHEN B
Violation Issued: No

Process/Item: Hot Holding
Temperature: 161 Degrees Fahrenheit - Location: CHICKEN - STEAM TABLE, KITCHEN B
Violation Issued: No

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

GENERAL COMMENTS:

DISCUSSED EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG IS USED ON-SITE.

ALL FOOD IS PREPARED IN THE SITE A KITCHEN AND TRANSPORTED OVER BY INSULATED CAMBROS TO THE SITE B KITCHEN. ALL FOOD IS MADE FOR SAME DAY SERVICE AND ANY LEFTOVERS ARE PROVIDED TO STAFF OR ARE DISCARDED.

LOGS ARE USED TO RECORD TEMPERATURES OF COLD HOLDING TEMPERATURES, COOKING TEMPERATURES, AND SANITIZER CONCENTRATIONS.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1020221142 of 10/17/22.

Certified Food Protection Manager: Barry Ahl

Certification Number: FM3129 Expires: 06/26/24

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley B
Ashley B

651-201-4500

Report #: 1020221142

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	10/17/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Vista Praire Monarch Meadows	2135 Lor Ray Drive	North Mankato, MN	56003	5073440059

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038578		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status					COS	R
Supervision						
1	IN	OUT		PIC knowledgeable; duties & oversight		
2	IN	OUT	N/A	Certified food protection manager, duties		
Employee Health						
3	IN	OUT		Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN	OUT		Proper use of reporting, restriction & exclusion		
5	IN	OUT		Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices						
6	IN	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN	OUT	N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands						
8	IN	OUT	N/O	Hands clean & properly washed		
9	IN	OUT	N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	OUT		Adequate handwashing sinks supplied/accessible		
Approved Source						
11	IN	OUT		Food obtained from approved source		
12	IN	OUT	N/A N/O	Food received at proper temperature		
13	IN	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination						
15	IN	OUT	N/A N/O	Food separated and protected		
16	IN	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	IN	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status					COS	R
Time/Temperature Control for Safety						
18	IN	OUT	N/A	N/O Proper cooking time & temperature		
19	IN	OUT	N/A	N/O Proper reheating procedures for hot holding		
20	IN	OUT	N/A	N/O Proper cooling time & temperature		
21	IN	OUT	N/A	N/O Proper hot holding temperatures		
22	IN	OUT	N/A	Proper cold holding temperatures		
23	IN	OUT	N/A	N/O Proper date marking & disposition		
24	IN	OUT	N/A	N/O Time as a public health control: procedures & records		
Consumer Advisory						
25	IN	OUT	N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations						
26	IN	OUT	N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances						
27	IN	OUT	N/A	Food additives: approved & properly used		
28	IN	OUT		Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures						
29	IN	OUT	N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

				COS	R
Safe Food and Water					
30	IN	OUT	N/A Pasteurized eggs used where required		
31			Water & ice obtained from an approved source		
32	IN	OUT	N/A Variance obtained for specialized processing methods		
Food Temperature Control					
33			Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	N/A N/O Plant food properly cooked for hot holding		
35	IN	OUT	N/A N/O Approved thawing methods used		
36			Thermometers provided & accurate		
Food Identification					
37			Food properly labled; original container		
Prevention of Food Contamination					
38			Insects, rodents, & animals not present		
39			Contamination prevented during food prep, storage & display		
40			Personal cleanliness		
41			Wiping cloths: properly used & stored		
42			Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 10/27/22

Inspector (Signature)