Protecting, Maintaining and Improving the Health of All Minnesotans

October 4, 2023

Licensee
Vista Prairie at Garnette Gardens
511 Dekalb Street
Redwood Falls, MN 56283

RE: Project Number(s) SL30391015

Dear Licensee:

On September 27, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 8, 2022, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

December 23, 2022

Licensee
Vista Prairie At Garnette Gardens
511 Dekalb Street
Redwood Falls, MN 56283

RE: Project Number(s) SL30391015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 8, 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.

LICENSING ORDERS
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 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $3,000.00

The total amount you are assessed is $3,500.00. 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 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

Free from Maltreatment reconsideration 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

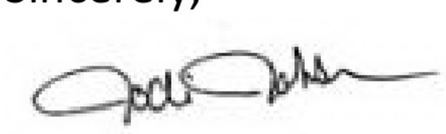
REQUESTING A HEARING

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30391	A. BUILDING: _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT GARNETTE GARDENS	511 DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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: SL#30391015 On December 5, 2022, through December 8, 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 76 residents, all of whom received services under the provider's Assisted Living license. 0510: An immediate correction order was issued on December 6, 2022. The immediacy was removed; however, non-compliance remains at a level 3, widespread scope (l).	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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: Executive director/licensed assisted living director in residence (ED/LALDIR)-A had a license effective through March 16, 2023. However, ED/LALDIR-A's license lacked an organization listed as the Director of Record with BELTSS. LALD-I had a license effective through October 31, 2023. However, LALD-I's license lacked an organization listed as the Director of Record with BELTSS. On December 5, 2022, at 2:47 p.m. ED/LALDIR-A stated LALD-I was her mentor;	0 110		

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0 110	Continued From page 2 however, confirmed the licenses lacked identification of the Director of Record as required. ED/LALDIR-A indicated she was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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: 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	0 480		

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0 480	Continued From page 3 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 December 6, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=I	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 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 that complies with accepted health care, medical and nursing standards for infection control. This had the potential to affect all residents, staff, and visitors. This resulted in an immediate correction	0 510		

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0 510	Continued From page 4 order on December 6, 2022, at 9:00 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 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 December 5, 2022, at 12:06 p.m. during the facility tour, executive director/licensed assisted living director in residence (ED/LALDIR)-A stated the facility currently had one resident (R7) who had tested positive for COVID-19. On December 5, 2022, at 1:46 p.m. the surveyor observed a plastic three-drawer cart outside of R7's room that had hand sanitizer and goggles on top. The cart contained disposable gowns, gloves, and surgical masks. There was no signage on the door to indicate precautions should be taken or that the resident was in isolation. On December 6, 2022, at 8:20 a.m. unlicensed personnel (ULP)-D stated R7 was on precautions for COVID-19. ULP-D stated there was a three drawer cart outside of the room that contained the required personal protective equipment (PPE) including gowns, gloves, goggles, and surgical masks. ULP-D stated N-95 masks were not required to enter R7's room and did not believe the facility had N-95 masks available for use. ULP-D further stated after leaving R7's room, PPE was removed in the hallway and disposed	0 510		

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0 510	Continued From page 5 into the garbage container outside of R7's room. On December 6, 2022, at 8:40 a.m. registered nurse (RN)-B stated [The Licensee] had a supply of N-95 masks but were not in use by staff for COVID-19 positive residents. RN-B further stated staff should be using a N-95 when working with a COVID-19 positive resident and doffing inside of the room at the doorway. RN-B further verified a sign should be in place to alert others for the type of precautions required. On December 6, 2022, at 8:45 a.m. the surveyor and RN-B observed ULP-E doffing PPE and placing into a covered garbage container outside of R7's room. When interviewed at that time, ULP-E stated she had assisted R7 with a shower wearing a surgical mask and confirmed the facility had not offered N-95 masks for use in the COVID positive resident rooms. RN-B verified at this time again, PPE should be removed inside of the room and a N-95 mask should be used. The licensee's Transmission-Based Precautions policy dated July 19, 2021, indicated: Transmission-based precautions will be used for residents who are documented or suspected to infection or communicable diseases that may be transmitted to others. 3. Transmission-Based Precautions: · The organization will follow the CDC (centers for disease control) recommendations on whether or not a resident requires transmission-based precautions based upon their individual illness. · Post a notice on the door of the resident's room so that all personnel and visitors are aware of the isolation precautions. · Place necessary equipment and supplies that will be needed during isolation. · Make sure that an adequate supply of	0 510		

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0 510	Continued From page 6 antiseptic soap and paper towels are maintained in the room during the isolation period. · All staff that has contact with the resident(s) will be in-serviced on appropriated transmission-based precautions. Minnesota Department of Health COVID-19 Source Control (Masking, PPE, and Testing Grid) dated November 2, 2022, identified a resident with a positive COVID-19 test requires full COVID-19 PPE: respirator, eye protection, isolation gown, and gloves. TIME PERIOD FOR COMPLETION: Immediate. On December 7, 2022, the immediacy of correction order 0510 was removed; however, non-compliance remains at a scope and level of (I). TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain records for five of five residents (R4, R5, R1, R2, R3) for whom they provided services included authentication of documentation for pool agency staff, with the	0 690		

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0 690	Continued From page 7 name and title of the person. 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: R4's Service Plan Agreement effective October 26, 2022, indicated the resident received services including housekeeping, laundry, assistance with activities of daily living, oxygen management, blood sugar checks, and medication administration including insulin. R4's Medication Administration Record (MAR) dated November 2022, and Service Checkoff List dated November 2022, were reviewed. Both forms had a list of staff identified at the bottom of each page with their name, title, and initials. The pool agency staff were identified as "Tree Grape, RA" (resident assistant) with either the initials "gt1" or "gggt". R5's Service Plan Agreement effective October 4, 2022, indicated services included housekeeping, laundry, assistance with bathing, grooming, dressing, and ambulation, blood sugar checks and insulin administration. R5's Service Checkoff List dated November 2022, was reviewed. The form had a list of staff identified at the bottom of each page with their name, title, and initials. The pool agency staff were identified as "Tree Grape, RA" with either	0 690		

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0 690	Continued From page 8 the initials "gt1" or "gggt." R1 R1's Service Plan Agreement dated June 30, 2022, indicated services included housekeeping, laundry, medication set up every 14 days, and blood sugar checks. The Service Plan did not include administration of oral medications. R1's MAR dated December 2022, and Service Checkoff List dated December 2022, were reviewed. The form had a list of staff identified at the bottom of each page with their name, title, and initials. The pool agency staff were identified as "Tree Grape, RA" with either the initials "gt1" or "gggt." R2 R2's Service Plan Agreement dated July 29, 2022, indicated services included housekeeping, laundry, assistance with bathing, blood sugar checks and insulin administration. The Service Plan did not include administration of oral medications. R2's MAR dated December 2022, and Service Checkoff List dated December 2022, were reviewed. The form had a list of staff identified at the bottom of each page with their name, title, and initials. The pool agency staff were identified as "Tree Grape, RA" with the initials "gggt." R3 R3's Service Plan Agreement dated June 27, 2022, indicated services included housekeeping, laundry, assistance with bathing, and medication management. R3's MAR dated December 2022, was reviewed.	0 690		

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0 690	Continued From page 9 The form had a list of staff identified at the bottom of each page with their name, title, and initials. The pool agency staff were identified as "Tree Grape, RA" with the initials "gggt." On December 7, 2022, at 2:52 p.m. registered nurse (RN)-B stated there were two pool agencies utilized at the facility and both pool agencies had logins that identified the employee as "Tree Grape, RA" with either the initials "gt1" or "gggt." RN-B stated there were binders at each community with login instructions for the pool agency staff to use. On December 8, 2022, at 11:26 a.m. executive director/licensed assisted living director in residence (ED/LALDIR)-A stated there were only two logins for pool staff to use, either gt1 or gggt. ED/LALDIR-A verified the only way to identify who was using the login was to compare it to the schedule; however, ED/LALDIR-A further stated more than one pool staff could be logged into the system on the same shift with those credentials. On December 8, 2022, at 11:30 a.m. registered nurse (RN)-H stated only one person should be using a login. "One login per employee" is the standard. The licensee's 2.38 Resident Record - Information and Content policy dated August 2021, indicated: all entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 690		

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VISTA PRAIRIE AT GARNETTE GARDENS	511 DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 690	Continued From page 10 (21) days	0 690		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition 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: On a facility tour on December 07, 2022, at approximately 1:30 p.m. with Executive director/licensed assisted living director in	0 800		

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	30391	A. BUILDING: _____ B. WING _____	12/08/2022

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0 800	Continued From page 11 residence (ED/LALDIR)-A and Maintenance/Housekeeper (M/H)-G it was observed that multiple emergency lights throughout the egress corridors were not operational upon testing. ED/LALDIR-A and M/H-G visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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	0 810		

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0 810	Continued From page 12 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: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements 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 December 07, 2022, at approximately 1:30 p.m. with Executive director/licensed assisted living director in residence (ED/LALDIR)-A and Maintenance/Housekeeper (M/H)-G it 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 fire safety and evacuation plan did not include procedures for resident	0 810		

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0 810	Continued From page 13 movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, ED/LALDIR-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not conduct drills twice per year per shift and every other month as required by statute but did not document, nor was able to verify that evacuation was practiced as part of the required drills. During interview, ED/LALDIR-A verified that there were no further documented drills for the facility other than what was provided and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated	01060		

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01060	Continued From page 14 and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for two of two residents (R6, R1) and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R6) who had not returned to the facility within four days.	01060		

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01060	Continued From page 15 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: R6 was admitted to the facility on March 23, 2018, and began receiving assisted living services on August 1, 2021. R6's Service Plan Agreement effective September 29, 2022, indicated R6 received services for housekeeping, laundry, wound care, assistance with activities of daily living, and medication administration. R6's progress note dated October 26, 2022, at 2:12 p.m. indicated the resident needed increased help with transfers, refused noon dose of Lasix (medication used to reduce extra fluid in the body), and refused to follow up with wound care. The progress note further indicated R6 expressed a need to go to the nursing home. R6's family member was notified and indicated the transfer would need to wait until his return in two weeks. R6's progress note dated October 27, 2022, at 11:26 a.m. indicated the resident was experiencing increased weakness, and difficulty with transfers requiring multiple staff members. R6's extremities continued to weep heavily, and the resident requested to go to the ER (emergency room) to be evaluated. A call was placed to 911 for transfer.	01060		

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01060	Continued From page 16 R6's Resident Discharge Summary dated November 4, 2022, indicated R6 was sent to the ER on October 27, 2022, and discharged to a skilled nursing facility on October 31, 2022. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On December 6, 2022, at 10:42 a.m. executive director/licensed assisted living director in residence (ED/LALDIR)-A confirmed a written notice related to R6's emergency relocation had not been completed, and further lacked notification to the Office of Ombudsman for Long-Term Care within four days that R6 had been relocated and had not returned to the facility. R1 R1 was admitted to the facility on January 6, 2020, and began receiving assisted living services on August 1, 2021.	01060		

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01060	Continued From page 17 R1's Service Plan Agreement dated June 30, 2022, indicated services included housekeeping, laundry, medication set up every 14 days, and blood sugar checks. R1's progress notes dated September 23, 2022, at 12:38 a.m. indicated R1 was sent to the emergency room earlier in the evening following two falls and increased weakness. The progress note included R1 had been admitted to hospital for pneumonia. Progress notes dated September 26, 2022, at 2:53 p.m. indicated R1 had returned to the facility at 11:00 a.m. after his stay at the hospital. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On December 8, 2022, at 9:45 a.m. registered nurse (RN)-J confirmed a written notice related to R1's emergency relocation had not been completed. RN-J stated she was aware of the statute but had misunderstood the requirement.	01060		

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01060	Continued From page 18 The licensee's 1.10 Emergency Relocation policy effective/revised August 1, 2022, indicated: 1. In the event of an emergency relocation, [The Licensee] will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider. c. Contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for the agency to which the resident may submit an appeal. a. The resident, legal representative, and designated representative b. For resident who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. 5. Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the contract termination process. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		

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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 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for three of five residents (R5, R1, R2,). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 20 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: R5 R5's diagnoses included diabetes, hypothyroidism (underactive thyroid), and hypertension (high blood pressure). R5's Service Plan Agreement dated October 4, 2022, indicated services included housekeeping, laundry, assistance with bathing, grooming, dressing, and ambulation, blood sugar checks and insulin administration. The Service Plan did not include administration of oral medications. R5's physician orders dated November 30, 2022, included one medication for cholesterol, three for blood pressure, one for hypothyroidism, and one long-acting and one short-acting insulin injectable medication for diabetes. On December 7, 2022, at 8:29 a.m. unlicensed personnel (ULP)-K was observed performing a blood sugar check for R5 in the resident's room. ULP-K confirmed R5 had morning oral medications also but preferred to take them after eating her breakfast. R1 R1's diagnoses included hypertension, atrial	01650		

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01650	Continued From page 21 fibrillation (irregular heartbeat that can lead to blood clots), and diabetes. R1's physician orders dated June 24, 2022, included one medication for cholesterol, one for reflux, two for blood pressure, one for hypothyroidism, two for diabetes, two supplements, and one blood thinner. R1's Service Plan Agreement dated June 30, 2022, indicated services included housekeeping, laundry, medication set up every 14 days, and blood sugar checks. The Service Plan did not include administration of oral medications. On December 7, 2022, at 8:40 a.m. ULP-D was observed to administer insulin and oral medications from a mediminder (medication dispenser box) to R1. R2 R2's diagnoses included diabetes, major depressive disorder, and hypertension. R2's Service Plan Agreement dated July 29, 2022, indicated services included housekeeping, laundry, assistance with bathing, blood sugar checks and insulin administration. The Service Plan did not include administration of oral medications. R2's physician orders dated October 20, 2022, included two medications for bone density, three for blood pressure, five supplements, one for constipation, one blood thinner, one for mood, one for cholesterol, one long-acting and one short-acting insulin injectable medication for diabetes. On December 6, 2022, at 11:33 a.m. ULP-D was	01650		

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01650	Continued From page 22 observed to administer insulin to R2 and indicated she had already administered R2's oral medications earlier in the morning. On December 7, 2022, at 2:42 p.m. registered nurse (RN)-B verified medication administration was lacking from R5, R1, and R2's service plans. The licensee's Contents of Service Plans policy dated August 1, 2021, identified service plans would include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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 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	01730		

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01730	Continued From page 23 directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for two of five residents (R5, R2) with records reviewed. 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	01730		

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01730	Continued From page 24 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 5, 2022, at 11:31 a.m. registered nurse (RN)-B confirmed the licensee provided medication management services to the residents at the facility. R5's diagnoses included diabetes, hypothyroidism (underactive thyroid), and hypertension (high blood pressure). R5's Service Plan Agreement dated October 4, 2022, indicated R5 received services which included bathing, grooming, ambulation assistance, blood sugar checks and insulin administration. R5's physician orders dated November 30, 2022, included one medication for cholesterol, three for blood pressure, one for hypothyroidism, and one long-acting and one short-acting insulin injectable medication for diabetes. On December 6, 2022, at 11:27 a.m. unlicensed personnel (ULP)-F was observed administering R5 an insulin injection. R2 R2's diagnoses included diabetes, major depressive disorder, and hypertension. R2's Service Plan Agreement dated July 29, 2022, indicated services included housekeeping, laundry, assistance with bathing, blood sugar	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30391	A. BUILDING: _____ B. WING _____	12/08/2022

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VISTA PRAIRIE AT GARNETTE GARDENS	511 DEKALB STREET REDWOOD FALLS, MN 56283

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01730	Continued From page 25 checks and insulin administration. The Service Plan did not include administration of oral medications. R2's physician orders dated October 20, 2022, included two medications for bone density, three for blood pressure, five supplements, one for constipation, one blood thinner, one for mood, one for cholesterol, one long-acting and one short-acting insulin injectable medication for diabetes. On December 6, 2022, at 11:33 a.m. ULP-D was observed to administer insulin to R2. R5 and R2's individual medication management plans lacked: -a statement describing the medication management services that will be provided; -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; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; and -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.	01730		

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01730	Continued From page 26 On December 7, 2022, at 9:18 a.m. registered nurse (RN)-B confirmed R5 did not have a medication management plan with all required content included in the resident's record. On December 8, 2022, at 12:04 p.m. RN-B confirmed R2 did not have a medication management plan with all required content included in the resident's record. The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 2021, noted prior to providing medication prior to providing medication management services, a licensed nurse, licensed health professional, or authorized prescriber would conduct an assessment to determine what medication management services would be provided and how the services would be provided. 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	01750		

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01750	Continued From page 27 in the resident's records; 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 delegated procedures were followed by two of two unlicensed personnel (ULP-F and ULP-D) observed during medication administration. 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: R5 R5's Service Plan Agreement dated October 4, 2022, indicated services included insulin pen administration and blood sugar checks. R5's Physician Orders dated November 30, 2022, included Novolog (fast-acting insulin) Flexpen 100 units/milliliter (ml), inject as per sliding scale: if 0-150=0 units, 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, greater than 400 call provider. On December 6, 2022, at 11:25 a.m. ULP-F was observed performing a blood sugar check for R5 in her room. ULP-F donned gloves and applied a lancet to one of R5's fingertips. ULP-F then	01750		

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01750	Continued From page 28 squeezed a drop of blood from the affected fingertip and wiped it off with a clean gauze pad. ULP-F then squeezed another drop of blood from R5's affected fingertip and applied the blood to the test strip in the glucometer. ULP-F did not cleanse R5's fingertip with alcohol nor did she direct the resident to wash her hands prior to the blood sugar check. At 11:27 a.m., ULP-F returned to the medication cart and stated R5's blood sugar was 256 which indicated the resident would receive 6 units of the Novolog insulin per the sliding scale order. ULP-F obtained R5's Novolog Flexpen from the med cart, removed the cap, and proceeded to apply a new needle. ULP-F did not cleanse the end of the insulin pen prior to applying the needle. ULP-F then primed the insulin pen by dialing it to two units and wasting the two units of insulin, then dialed the pen to six units. ULP-F then returned to R5's room and administered the insulin in the resident's lower left abdomen. ULP-F did not use an alcohol pad to cleanse R5's injection site prior to administering the insulin. Immediately following the observation, ULP-F confirmed she had not cleansed R5's skin with an alcohol pad prior to using the lancet on R5's fingertip to obtain the blood sugar nor on R5's lower left abdomen prior to injecting the insulin. When ULP-F was asked about using an alcohol wipe to cleanse the insulin pen prior to applying needle, ULP-F stated she had never done that before. R2 R2's Service Plan Agreement dated July 29, 2022, indicated services included blood sugar checks and insulin administration. R2's physician orders dated October 20, 2022, included an order for Novolog Flexpen 100	01750		

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01750	Continued From page 29 units/ml 5 units subcutaneously with meals three times a day and per sliding scale: if blood sugar 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, greater than 401=call provider. On December 6, 2022, at 11:33 a.m. ULP-D was observed to perform a blood sugar check for R2 in her room. ULP-D sanitized hands, donned gloves, and used a self-retractable lancet to R2's fingertip. ULP-D then squeezed a drop of blood from the affected fingertip and wiped it off with a cotton ball. ULP-D then squeezed another drop of blood from the affected fingertip and applied the blood to the test strip in the glucometer. ULP-D did not cleanse R2's fingertip with alcohol nor did she direct the resident to wash her hands prior to the blood sugar check. ULP-D notified the registered nurse (RN) of R2's blood sugar result of 105. RN verified to ULP-D that no extra insulin was required per sliding scale. ULP-D stated R2 would receive 5 units of Novolog FlexPen as ordered. ULP-D removed the cap of the Novolog Flexpen and attached a new needle. ULP-D did not cleanse the end of the insulin pen prior to applying the needle. ULP-D primed the insulin pen by wasting two units, then dialed the pen to five units. ULP-D administered the insulin in the resident's lower right abdomen. ULP-D did not use an alcohol pad to cleanse R2's injection site prior to administering the insulin. Immediately following the observation, ULP-D confirmed she had not cleansed R2's skin with an alcohol pad prior to using the lancet on R2's fingertip to obtain the blood sugar, prior to applying a new needle to the insulin pen, nor on R2's lower right abdomen prior to injecting the insulin. ULP-D stated she was told a few years ago she no longer needed to use alcohol pads for the procedures as noted above.	01750		

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01750	Continued From page 30 On December 6, 2022, at 4:12 p.m. RN-B stated staff are trained to clean the finger with alcohol and allow to dry prior to using lancet to obtain drop of blood. RN-B further stated the end of an insulin pen should be cleansed with an alcohol pad prior to putting a new needle on, and skin cleansed with alcohol prior to injecting. The licensee's Delegated Nursing Task with Medications: Blood Glucose Monitoring procedure undated, instructed: 7. Cleanse client's finger The licensee's Delegated Nursing Task with Medications: Insulin Injection: Pen procedure undated, instructed: 3. Gather supplies, including insulin pen stored at room temperature and alcohol wipes 8. Wipe the rubber stopper with an alcohol swab 9. Attach needle after removing the protective cap. 13. Check MAR (medication administration record) for rotation of sites. Prepare injection site with alcohol wipe. Allow the alcohol to dry. 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	01760		

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01760	Continued From page 31 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 medications were administered as prescribed for one of seven residents (R1) with records reviewed. 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's Service Plan Agreement dated June 30, 2022, indicated services included housekeeping, laundry, medication set up every 14 days, and blood sugar checks. The Service Plan did not include administration of medications. R1's physician orders dated June 24, 2022, included Lantus Solostar (long-acting insulin pen) 100 units/milliliter (ml) inject 35 units subcutaneously twice daily, chart rotation site. Rub between hands. Resident will dial 2 units to	01760		

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01760	Continued From page 32 prime then press button to go back to 0. Then resident dials to 35 units, injects, and count for 10 seconds. RA (resident assistant) to check units, but MAY NOT DIAL PEN OR INJECT. On December 7, 2022, at 8:40 a.m. unlicensed personnel (ULP)-D was observed to obtain R1's Lantus SoloStar pen from the medication cart, removed the cap of the insulin pen, cleansed the end of the insulin pen with an alcohol pad, and applied a new needle. ULP-D primed the insulin pen by wasting two units, then dialed the pen to 35 units. ULP-D showed R1 the dialed number of units on the pen and he proceeded to lift his shirt where ULP-D administered the insulin into R1's left abdomen. On December 7, 2022, at 11:24 a.m. ULP-D verified R1's order had not been followed and indicated she had always primed, dialed the insulin amount, and administered the insulin for R1. On December 7, 2022, at 2:40 p.m. registered nurse (RN)-B stated staff should administer medications as prescribed. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, noted medications need to be administered according to the "6 Rights": a. Right person b. Right medication c. Right time d. Right route (by mouth, eye drops, topical, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right chart/record to document that the medication was taken	01760		

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01760	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly and included the expiration date of a time-dated drug, for one of one resident (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 physician orders dated October 20, 2022, included an order for Novolog Flexpen (a fast-acting insulin pen) 100 units/milliliter (ml) 5 units subcutaneously with meals three times a	01890		

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01890	Continued From page 34 day and per sliding scale: if blood sugar 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, greater than 401= call provider. R2's medication administration record (MAR) dated December 2022, included the same order for Novolog Flexpen 100 units/ml 5 units subcutaneously with meals three times a day and per sliding scale: if blood sugar 151-200= 2 units, 201-250= 4 units, 251-300= 6 units, 301-350= 8 units, 351-400= 10 units, greater than 401= call provider. On December 6, 2022, at 11:33 a.m. unlicensed personnel (ULP)-D obtained R2's blood sugar reading of 105. ULP-D notified the registered nurse (RN) of blood sugar result and received verification no extra insulin to be administered per sliding scale. The surveyor examined R2's Novolog Flexpen label and noted the label did not match the order. The label had R2's name on it, but it read "inject 2-7 units subcutaneously four times a day per sliding scale". The insulin further lacked a date open. ULP-D verified the label did not match the order and did not have an opened date. On December 6, 2022, at 4:12 p.m. RN-B stated all medications should have a label that matches the physician order. RN-B further stated all insulin should have a date open/expiration sticker. Novolog Full Prescribing Information Recommended Storage Instructions revised January 2015, identified the Novolog Flex can be opened at room temperature up to 28 days. The licensee's Storage of Medications policy dated August 1, 2021, identified a prescription	01890		

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01890	Continued From page 35 medication must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02110 SS=E	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and	02110		

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02110	Continued From page 36 how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for four of five residents (R1, 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 included: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021.	02110		

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02110	Continued From page 37 R1, R3, R4, and R5's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On December 8, 2022, at 8:15 a.m. executive director/licensed assisted living director in residence (ED/LALDIR)-A verified the inclusive list of dementia care policies had not been provided to each resident and/or representative as required. The licensee's 3.00 Assisted Living with	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30391	A. BUILDING: _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT GARNETTE GARDENS	511 DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 38 Dementia Care Additional Required Policies policy dated August 2021, noted the above policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. The policies can be provided in electronic format if desired. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. 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) and was issued at a widespread scope (when problems are pervasive	02140		

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02140	Continued From page 39 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on December 5, 2022, at 11:30 a.m. executive director (ED)/licensed assisted living director in residence (LALDIR)-A stated being unsure who was certified to oversee training staff in the care of individuals with dementia but would check into it. On December 8, 2022, at 9:25 a.m. registered nurse (RN)-J and RN-B stated they had not completed any approved competency or knowledge tests required for supervising staff in an assisted living facility with dementia care. RN-J stated the director of nursing that left last month may have had it, but no one currently held a certificate. The licensee's 3.01 ALDC Additional Dementia Staff Training policy dated August 2021, identified: 3. Persons conducting such training will be qualified to train in the care of individuals with dementia. Qualifications will include the following: a. Two years or work experience related to Alzheimer's disease or other dementia, or in other health care, gerontology, or another related field, and; b. Has completed and passed training approved by MDH. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		

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	30391	A. BUILDING: _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT GARNETTE GARDENS	511 DEKALB STREET REDWOOD FALLS, MN 56283

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02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced	02170		

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	30391	A. BUILDING: _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT GARNETTE GARDENS	511 DEKALB STREET REDWOOD FALLS, MN 56283

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02170	Continued From page 41 by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions, and failed to develop an individualized activity plan based on the evaluation, for four of five residents (R5, R1, R2, R3) who received services under an assisted living with dementia care license. 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 held an assisted living with dementia care license, effective August 1, 2022. R5 R5's diagnoses included diabetes, hypothyroidism (underactive thyroid), and hypertension (high blood pressure). R5's Service Plan Agreement dated October 4, 2022, indicated R5 received services which included bathing, grooming, ambulation assistance, blood sugar checks and insulin administration. On December 6, 2022, at 11:44 a.m. unlicensed personnel (ULP)-F was observed assisting R5 with ambulation from the resident's room to the dining room. R5 utilized a 4-wheeled walker; she had a gait belt around her waist which ULP-F held	02170		

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	30391	A. BUILDING: _____ B. WING _____	12/08/2022

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VISTA PRAIRIE AT GARNETTE GARDENS	511 DEKALB STREET REDWOOD FALLS, MN 56283

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02170	Continued From page 42 onto to provide assistance with stability. R5's Initial Activity Assessment dated September 26, 2020, the assessment indicated past and current interests, and a limited physical assessment. R5's record lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R5's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R1 R1's diagnoses included hypertension, atrial fibrillation (irregular heart beat that can lead to blood clots), and diabetes. R1's Service Plan Agreement dated June 30, 2022, indicated services included housekeeping, laundry, medication set up every 14 days, and blood sugar checks. The Service Plan did not include administration of oral medications. On December 7, 2022, at 8:40 a.m. ULP-D was observed to administer insulin and oral medications from a mediminder (medication dispenser box) to R1. R1's Initial Activity Assessment dated January 10, 2020, identified past and current interests, and a limited physical assessment. R1's record lacked the following: - current abilities and skills; - emotional and social needs and patterns;	02170		

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	30391	A. BUILDING: _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 43 - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R1's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R2 R2's diagnoses included diabetes, major depressive disorder, and hypertension. R2's Service Plan Agreement dated July 29, 2022, indicated services included housekeeping, laundry, assistance with bathing, blood sugar checks and insulin administration. The Service Plan did not include administration of oral medications. On December 6, 2022, at 11:33 a.m. ULP-D was observed to administer insulin to R2. R2's Initial Activity Assessment undated, identified past and current interests, and a limited physical assessment. R2's record lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R2's record did not include evidence of an individualized activity plan based on the resident's activity assessment. R3	02170		

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02170	Continued From page 44 R3's diagnoses included diabetes, weakness, and dementia (memory loss). R3's Service Plan Agreement dated June 27, 2022, indicated services included housekeeping, laundry, assistance with bathing, and medication management. R3's Initial Activity Assessment dated January 18, 2021, identified past and current interests, and a limited physical assessment. R3's record lacked the following: - current abilities and skills; - emotional and social needs and patterns; - current physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. R3's record did not include evidence of an individualized activity plan based on the resident's activity assessment. On December 8, 2022, at 10:25 a.m. activity director (AD)-L confirmed she only completed resident activity assessments upon admission and did not develop an activity plan for any of the residents in the facility. AD-L stated the prior memory care manager would complete an activity care plan for residents residing in the memory care unit only, and confirmed the other residents in the facility did not have an activity plan. AD-L further confirmed the activity assessment did not contain all required content. The licensee's 3.05 ALDC Life Enrichment Programs, Activities & Outdoor Space policy dated August, 2021 identified: 2. Each resident must be evaluated for activities	02170		

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02170	Continued From page 45 according to the licensing rules of the facility. In addition, the evaluation must address the following: -past and current interests -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate, and -identification of activities for behavioral interventions 3. An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

DEPARTMENT OF HEALTH

Type: Full
Date: *12/06/22*
Time: 10:30:00
Report: 1033221192

Food and Beverage Establishment Inspection Report

Location:
Vp At Garnette Gardens
511 Dekalb Street
Redwood Falls, MN56283
Redwood County, 64

Establishment Info:
ID #: 0038402
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5076448500
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Butter is being stored on the counter at room temperature. Manufacture states this butter must be stored in a refrigerator.
Comply By: 12/06/22

4-500 Equipment Maintenance and Operation
4-501.114C1 ***** Priority 1 *****
MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

Dish machine was measured at 0ppm. Employee serviced machine and is properly dispensing chlorine sanitizer.

Corrected on Site

4-300 Equipment Numbers and Capacities
4-302.14 ***** Priority 2 *****
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Chlorine test kit is expired.

Comply By: 12/20/22

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

Unlabeled spray bottle found in food preparation area. Employee labeled spray bottle with what is being used inside it.

Corrected on Site

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

Employee is thawing ground beef hamburger patties at room temperature on the counter.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Facility is using unapproved residential crock pots.

Comply By: 12/06/22

Surface and Equipment Sanitizers

Quaternary Ammonium: = 400 at Degrees Fahrenheit
Location: Red Bucket
Violation Issued: No

Chlorine: = 0 at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: Yes

Food and Equipment Temperatures

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

Type: Full
Date: *12/06/22*
Time: 10:30:00
Report: 1033221192
Vp At Garnette Gardens

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Cooked Chicken-Cooler
Violation Issued: No

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

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Back Freezer
Violation Issued: No

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

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1033221192 of 12/06/22.

Certified Food Protection Manager: Kayla L Forseth

Certification Number: FM85204 Expires: 08/02/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Kayla L Forseth

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us