Electronically Delivered

April 11, 2025

Licensee
Vista Prairie At Windmill Ponds
715 Victor Street
Alexandria, MN 56308

RE: Project Number(s) SL21642016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21642	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT WINDMILL PONDS	715 VICTOR STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21642016-0 On March 10, 2025, through March 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 53 residents; 53 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (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 ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (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 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 March 10, 2025, at 9:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R1's diagnoses included diabetes and diabetic	0 630		

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0 630	Continued From page 2 neuropathy (nerve damage caused by diabetes). R1's service plan dated February 7, 2025, indicated R1 received medication administration, blood glucose monitoring, and assistance with bathing, dressing, toileting, housekeeping and laundry. On March 11, 2025, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-E provide scheduled morning medication administration to R1. R1's resident record contained an IAPP dated November 19, 2024, which addressed R1's risk of self-abuse, however, lacked the residents susceptibility to be abused by another individual, including other vulnerable adults and risk of abusing other vulnerable adults. On March 12, 2025, at 2:00 p.m., CNS-B stated the IAPP was completed prior to CNS-B starting employment with the licensee. CNS-B stated CNS-B was aware of the IAPP requirements and must have missed R1's susceptibility of being abused by others and abuse to others when CNS-B reviewed the IAPP. The licensee's 5.0 IAPP policy dated August 1, 2021, indicated the IAPP would include the residents susceptibility to be abused by another individual, including other vulnerable adults, the residents risk of abusing other vulnerable adults, and the resident's risk for self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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01500	Continued From page 3	01500		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 4 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees performing direct care services completed the required eight hours of annual training for one of one employee, (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 10,	01500		

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01500	Continued From page 5 2025, at 9:30 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-F was hired on November 22, 2017, and began to provide direct care services to the licensee's residents on August 1, 2021. ULP-F's employee record indicated ULP-F received 2024 annual training via online education courses and in-service training provided by the licensee. Online education transcripts indicated ULP-F completed 1.75 hours of courses in Person Centered Care, Annual Occupational Safety and Health Administration (OSHA) and Infection Control, and Abuse Prevention. Additionally, ULP-F received 4 hours of annual in-service training to include Assisted Living Bill of Rights, person centered care and planning, policies and procedures review, a skills fair and various other subjects. ULP'S 2024 annual training hours totaled 5.75, which was 2.25 hours short of the 8-hour requirement. On March 12, 2025, at 2:25 p.m., registered nurse (RN)-D and surveyor reviewed ULP-F's annual training documents. RN-D stated annual training starts January 1 and goes through December 31 each calendar year. RN-D stated ULP-F did not have the required 8 hours of training for 2024. RN-D stated RN-D was unsure why the annual training was not completed. The licensee's 5.06 Annual Required staff Training policy dated August 2021, indicated all staff that perform direct care services at [management company name] will complete at least eight (8) hours of annual training for each 12 months of employment	01500		

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01500	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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 two	01530		

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01530	Continued From page 7 employees, (unlicensed personnel/ULP-E) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 10, 2025, at 9:30 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. ULP-E was hired on December 2, 2024, to provide direct care services to the licensee's residents. On March 11, 2025, at 7:25 a.m., the surveyor observed ULP-E provide scheduled morning medication administration for R1. ULP-E's employee record indicated ULP-E completed 6.5 hours of on-line dementia training. On March 11, 2025, at 1:00 p.m., licensed assisted living director (LALD)-A verified ULP-E had not completed 8 hours of dementia training and was missing 1.5 hours. On March 12, 2025, at 10:55 a.m., LALD-A stated as of March 11, 2025, ULP-E had worked approximately 275 hours. LALD-A stated the	01530		

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01530	Continued From page 8 on-line auto enroll for new hire orientation was missing dementia training hours for ULP-E. LALD-A stated LALD-A was unsure why ULP-E was not enrolled for 8 hours of dementia training. ULP-E's employee record lacked eight hours of dementia training within 160 hours of the employee start date for direct care employees. The licensee's 5.03 Dementia Training policy dated August 2021, indicated direct care employees will complete eight hours of initial training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01690 SS=F	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	01690		

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01690	Continued From page 9 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 observation, interview, and record review, the licensee failed to ensure accountability of controlled substances was maintained by failure to implement the policy for six of six residents (R5, R6, R7, R8, R11, R13). 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 the potential to affect a large portion or all of the residents). The findings include: On March 10, 2025, at 9:30 a.m., during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor	01690		

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01690	Continued From page 10 (CNS)-B stated the licensee provided medication management for the licensee's residents. On March 10, 2025, at 12:14 p.m., the surveyor and registered nurse (RN)-D observed a secured cupboard in the locked nursing office on second floor containing multi dose blister medication cards of narcotics. RN-D stated when a resident was on hospice, four multi dose blister medication cards were sent for hospice residents. RN-D stated only one multi dose card was kept in the medication carts. RN-D stated only one multi dose medication card was kept in the medication cart for ease of counting for the ULPs, and the extra medication cards were kept in the cupboard. RN-D stated the nurses replenish the medication carts when needed. RN-D and surveyor observed a handwritten document taped to the inside of the cupboard that indicated the resident name, prescription number, name of medication, dose and number of multi dose blister medication cards and amounts in each card and signed by one nurse. RN-D stated the extra narcotic medication cards were counted weekly by the nurses, however, did not have the weekly documentation. The following narcotics in the cupboard were verified by RN-D: - lorazepam (anxiety) 0.5 milligram (mg), 30 tablets for R5; - morphine (pain) 5 mg, 30 tablets for R6; and - morphine (pain) 5 mg, 60 tablets for R7. R5, R6, and R7's controlled substances lacked narcotic log records as per licensee policy. On March 10, 2025, at 12:20 p.m., the surveyor and RN-D observed a secured refrigerator in a second secured nursing office on the second floor with a clipboard with log counts of the medications, signed by one nurse. RN-D stated	01690		

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01690	Continued From page 11 the controlled medications are counted weekly, when the nurse fills the single dose syringes or takes medication from the closeable plastic bag (RN-D stated only a certain number of tablets were put in the tramadol bottle for ease of counting for the ULPs, and were kept in the refrigerator to be double locked) to replenish the bottle in the medication cart, however, there was only one signature on the controlled narcotic logs. RN-D verified the following narcotics in the refrigerator: -opened morphine concentrate (pain) 20 mg/milliliter (ml), 23 ml in bottle for R8; -opened morphine concentrate (pain) 20 mg/milliliter (ml), 29 ml in bottle for R11; and -opened tramadol (pain) 50 mg, 43 tablets for R13, in a closeable plastic bag with handwritten name, prescription number, medication name and dose. R8, R11 and R13 's lacked narcotic log records with two staff signatures as per licensee policy. On March 10, 2025, at 12:25 p.m., RN-B stated RN-B should have been signing the count sheets, and the licensee should have had count sheets for the medication blister packs in the locked cupboard. March 10, 2025, at 12:40 p.m., CNS-B stated CNS-B was unaware the nurses were not following policy with the controlled medications the licensee was managing. The licensee's Controlled Substances/Schedule II Drugs policy dated August 1, 2021, indicated assisted living staff, including a licensed nurse whenever possible, will use a preferred practice of counting controlled drugs at the end of each shift if medications are stored securely outside of	01690		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA PRAIRIE AT WINDMILL PONDS	715 VICTOR STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01690	Continued From page 12 the resident's room. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediate to the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
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 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 ordered for one of one resident (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	01760		

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VISTA PRAIRIE AT WINDMILL PONDS	715 VICTOR STREET ALEXANDRIA, MN 56308

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01760	Continued From page 13 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 hypertension (high blood pressure), hyperlipidemia, (high cholesterol) and atrial fibrillation (irregular heartbeat). R11's service plan dated March 6, 2025, indicated R11 received medication management. On March 10, 2025, at 11:18 a.m., the surveyor and RN-D observed a Z-Pack (azithromycin dosage package of 6 tablets) dated January 14, 2025, with one tablet remaining in the medication cart on the third floor. R11's electronic medication administration record (EMAR) dated January 2024 indicated R11 was to receive: -azithromycin (for infection) 250 mg tablets, administer 2 tabs on day 1 (January 15, 2025) then 1 tablet by mouth the remainer [sic] days. January EMAR indicated R11 received the medication on January 16, 17, 18, and 19. On March 10, 2025, at 11:20 a.m., RN-D stated the medication order was added to the EMAR and the licensee may have not received the medication until January 16, 2025. RN-D stated the unlicensed personnel (ULP) should have contacted a nurse if there was not medication to give on January 15, 2025 or a tablet remained in	01760		

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VISTA PRAIRIE AT WINDMILL PONDS	715 VICTOR STREET ALEXANDRIA, MN 56308

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01760	Continued From page 14 the dose package. The licensee's 11.0 Medication Errors policy dated August 1, 2021, indicated staff will report any medication errors promptly to the Director of Health Services (RN) or nurse in charge. The RN or nurse in charge will immediately investigate any medication errors and will implement and document corrective actions to reduce the risk of similar medication errors in the future. The RN or nurse in charge will determine the potential harm to the client and contact the appropriate providers, which may include the physician, pharmacist and the client's family. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's recommendations 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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21642	A. BUILDING: _____ B. WING _____	03/13/2025

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01880	Continued From page 15 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 10, 2025, at 9:30 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On March 10, 2025, at 11:16 a.m., the surveyor and registered nurse (RN)-D observed the medication cart on the third floor. RN-D verified three unopened bottles of Latanoprost 0.005% inside the cart for R9. The pharmacy label indicated to refrigerate until opening. RN-D stated the bottles should have been refrigerated and was unsure who placed the eye drops in the cart. The manufacturer's instructions for latanoprost dated September 2020, indicated to store unopened latanoprost in the refrigerator at 36 degrees F to 46 degrees F. The licensee's 8.0 Storage of Medications dated August 1, 2021, indicated when secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890 SS=F	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 maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications and failed to monitor for expired medications for two of two medication storage carts. 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: THIRD FLOOR MEDICATION CART On March 10, 2025, at 11:13 a.m., the surveyor and registered nurse (RN)-D observed the medication cart. RN-D confirmed the following: -opened Spiriva Respimat inhaler 2.5 microgram (mcg) (treats lung diseases) for R8, which lacked open and expiration dates; -opened fluticasone propionate salmeterol diskus	01890		

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01890	Continued From page 17 100 mcg/50 mcg (treats lung diseases) for R8, which lacked original pharmacy label and open and expiration dates; -opened lispro kwik pen 100 units/milliliter (ml) (treats high blood glucose) for R10, which lacked open and expiration dates; -opened Lantus insulin pen 100 units/ml (treats high blood glucose) for R10, which lacked open and expiration dates; -opened Semglee insulin pen 100 unit/ml (treats high blood glucose) for R5, which lacked open and expiration dates; -polyethylene glycol (PEG)3350 powder (treats constipation) for R12 expired November 2024; -opened antacid regular strength liquid (stock medication) expired August 2024; and -two bottles of opened prednisolone/moxifloxacin/bromfenac eye drop (for eye infection) for R14 which lacked original pharmacy, and expired July 9, 2024, and August 13, 2024. SECOND FLOOR MEDICATION CART On March 10, 2025, at 12:31 p.m., the surveyor and RN-D observed the medication cart. RN-D confirmed the following: -opened Lantus 100 units insulin pen for R1, which lacked open and expiration dates. On March 10, 2025, at 12:35 p.m., RN-D stated time sensitive medications should have been labeled with open and expiration dates, all medications should have pharmacy labels and expired medications should be discarded and reordered. RN-D stated RN-D was unsure why the medications were not labeled or why expired medications were not discarded. The manufacturer instructions for Spiriva Respimat dated November 2021, indicated the	01890		

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01890	Continued From page 18 inhaler should be discarded at the latest three months after the first use or when the locking mechanism is engaged, whichever comes first. The manufacturer instructions for fluticasone propionate salmeterol diskus dated January 2019, indicated to discard one month after the foil pouch is opened or when the counter reads zero. The manufacturer instructions for lispro kwik pen dated March 2020, indicated to discard after 28 days of its first use, even if it still has insulin in it. . The manufacturer instructions for Lantus insulin pen dated June 2022, indicated to discard after 28 days after its first use, even if it still has insulin in it. The manufacturer instructions for Semglee insulin pen dated July 2021, indicated to discard after 28 days after its first use, even if it still has insulin in it. The licensee's Storage of Medications policy dated August 1, 2021, indicated a legend drug must be kept in its original container bearing the original prescription label with legible information stating prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, residents name, prescriber name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *03/11/25*
Time: 14:20:28
Report: 7935251035

Food and Beverage Establishment Inspection Report

Location:
Vp At Windmill Ponds Llc
715 Victor Street
Alexandria, MN56308
Douglas County, 21

Establishment Info:
ID #: 0038247
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207592132
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

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

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

Process/Item: Hot Holding
Temperature: 169 Degrees Fahrenheit - Location: Veggies
Violation Issued: No

Process/Item: Hot Holding
Temperature: 147 Degrees Fahrenheit - Location: S&S Chicken
Violation Issued: No

Type: Full
Date: *03/11/25*
Time: 14:20:28
Report: 7935251035
Vp At Windmill Ponds Llc

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

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

I acknowledge receipt of the MN Department of Health inspection report number 7935251035 of 03/11/25.

Certified Food Protection Manager: Stephanie Miller

Certification Number: 121305 Expires: 08/18/26

Signed: _____
Establishment Representative

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