Electronically Delivered

April 17, 2025

Licensee
Windy Acres Long Term Care Inc
7040 Lake Boulevard
Forest Lake, MN 55025

RE: Project Number(s) SL30515016

Dear Licensee:

On March 27, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 10, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 10, 2025 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 10, 2025, found not corrected at the time of the March 27, 2025, follow-up survey and/or subject to penalty assessment are as follows:

2040-Fire Protection And Physical Environment-144g.81 Subdivision 1

The details of the violations noted at the time of this follow-up survey completed on March 27, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on March 27, 2025, we identified the following violation(s):

0780-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (1) - $500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are**

assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

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

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

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

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

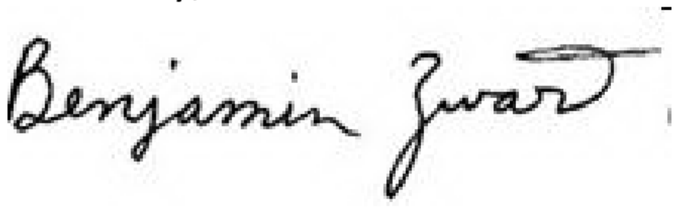
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

We urge you to review these orders carefully. If you have questions, please contact Benjamin J. Zwart

at 651-201-3715.

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

Sincerely,



Benjamin J. Zwart, Supervisor
State Engineering Services Section
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-800-337-9238 / 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30515	A. BUILDING: _____ B. WING _____	R 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDY ACRES LONG TERM CARE INC	7040 LAKE BOULEVARD FOREST LAKE, MN 55025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30515016-1 On March 24, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 8, 2025. At the time of the survey, there were 11 residents; 11 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	{0 680}		

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{0 680}	Continued From page 1 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not review during this survey.	
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all or a large portion of the residents and staff. 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). Findings include: On a facility tour on March 24, 2025, from 10:00 a.m. to 11:00 a.m., with clinical nurse supervisor (CNS)-B, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXISTING HARDWIRED SMOKE ALARMS The surveyor observed electrical boxes with covers in the basement, upstairs corridor near the basement door and in some of the resident sleeping rooms where existing hardwired smoke alarms (receiving power from the building electrical system) were replaced with battery only powered smoke alarms and interconnected with additional battery powered alarms. During the tour CNS-B, stated they did not think hardwired smoke alarms were available with technology to provide wireless interconnection to	0 780		

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0 780	Continued From page 3 the additional battery only powered smoke alarms. Existing hardwired smoke alarms that are replaced are required to be maintained as hardwired and interconnected with additional battery-operated smoke alarms in accordance with MSFC in Minnesota Rules Chapter 7511. These deficient conditions were visually verified by CNS-B, accompanying on the tour.	0 780		
{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) staff 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) Staff 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 4 least once per year. (f) Evacuation drills are required for staff 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:	{0 810}	Not review during this survey.	
{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:	{01890}	Not review during this survey.	
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and	{02040}		

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{02040}	Continued From page 5 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability 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) 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 of available documentation and interview were conducted March 24, 2025, at 10:00 a.m., with clinical nurse supervisor (CNS)-B, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During an interview on March 24, 2025, at 10:15 a.m., CNS-B, stated they were not clear on the requirement to perform and document a hazard vulnerability assessment detailing hazards with mitigation factors on and around the property.	{02040}		

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Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

February 6, 2025

Licensee
Windy Acres Long Term Care Inc
7040 Lake Boulevard
Forest Lake, MN 55025

RE: Project Number(s) SL30515016

Dear Licensee:

Please note: This letter amends the previous letter dated February 6, 2025. Specifically, the second paragraph in the previous letter was incorrect and has been removed.

The Minnesota Department of Health (MDH) completed a survey on January 10, 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.

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Electronically Delivered

February 6, 2025

Licensee
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7040 Lake Boulevard
Forest Lake, MN 55025

RE: Project Number(s) SL30515016

Dear Licensee:

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The enclosed State Form documents no violations. MDH documents the state correction orders using federal software. Please disregard the heading of the fourth column that states, "Provider's Plan of Correction." A plan of correction is not required.

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,

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: SL30515016-0 On January 6, 2025, through January 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 11 resident(s); 11 receiving services under the Assisted Living Facility with Dementia Care 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.	

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0 680	Continued From page 1	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. 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	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDY ACRES LONG TERM CARE INC	7040 LAKE BOULEVARD FOREST LAKE, MN 55025

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated emergency preparedness plan (EPP), lacked the required content: - a developed and maintained a comprehensive EPP, reviewed/updated annually; - a description of the population served by the licensee; - a process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - the development of policies/procedures to address: - subsistence needs for staff and residents; - procedures for tracking staff and residents; - the medical record documentation system to preserve resident information; - use of volunteers; and - roles under a wavier declared by secretary. - a communication plan that included: - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - evidence of conducted exercises to test the EP at least twice per year; and - a quarterly review of missing resident policy. On January 6, 2025, at 2:30 p.m., licensed assisted living director (LALD)-A agreed their emergency preparedness plan was missing some of the required content because she is in the process of updating the EPP and has not added	0 680		

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	30515	A. BUILDING: _____ B. WING _____	01/10/2025

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0 680	Continued From page 3 any of the updated information into the EPP yet. The licensee's undated Emergency Preparedness Plan policy, indicated the licensee's emergency preparedness plan is based on an all-hazards approach. Trained unlicensed staff will carry out emergency procedures outlined in this plan to maintain the health and safety of all residents and staff. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780		

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0 780	Continued From page 4 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all or a large portion of the residents and staff. 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). Findings include: On a facility tour on January 8, 2025, from 11:30 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-A, and clinical nurse supervisor (CNS)-B, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms one, two, three, four, five, six, seven, eight, and nine. OCCUPIED RESIDENT SLEEPING ROOMS	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30515	A. BUILDING: _____ B. WING _____	01/10/2025

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0 780	Continued From page 5 Resident sleeping rooms one, two, three, and five, emergency escape and rescue clear window opening measurements were 33 inches wide, 18.75 inches in height and 619 square inches in openable area. The windows were measured with LALD-A, CNS-B, and the surveyor present. The windows did not meet the minimum requirements for clear opening height and square inch openable area. Resident sleeping rooms six, seven, eight, and nine, emergency escape and rescue clear window opening measurements were 30 inches wide, 20.75 inches in height and 623 square inches in openable area. The windows were measured with LALD-A, CNS-B, and the surveyor present. The windows did not meet the minimum requirements for clear opening square inch openable area. UNOCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room four, emergency escape and rescue clear window opening measurements were 33 inches wide, 18.75 inches in height and 619 square inches in openable area. The window was measured with LALD-A, CNS-B, and the surveyor present. The window did not meet the minimum requirements for clear opening height and square inch openable area. The surveyor explained to LALD-A, and CNS-B, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening	0 780		

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0 780	Continued From page 6 area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. If the window clear opening measures the minimum of 20 inches in one direction, the other measurement will be more than 20 inches in order to achieve the total square inch area of 648 square inches. These deficient conditions were visually verified by LALD-A, and CNS-B, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. NON-IMMEDIATE Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all or a large portion of the residents and staff. 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 January 8, 2025, from 11:30 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-A, and clinical nurse supervisor (CNS)-B, the surveyor made the following	0 780		

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0 780	Continued From page 7 observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS The surveyor observed a lock on the interior of the marked main entrance door that required a key to open from the inside. The surveyor observed three separate locking devices requiring four operations to be completed in order for the door to release to open on the marked exit door leading outside near the kitchen. Marked exit doors are required to release to open in one operation without the use of keys, tools, or special knowledge in accordance with MSFC in Minnesota Rules Chapter 7511. EMERGENCY ESCAPE AND RESCUE The surveyor observed a window crank handle missing from the hardware on the emergency escape and rescue opening in resident sleeping room 13. INTERCONNECTED SMOKE ALARMS The smoke alarms were tested during the tour by LALD-A, and the surveyor observed the smoke alarms in the basement were not interconnected so activation of one alarm activates all alarms throughout the facility. EXISTING HARDWIRED SMOKE ALARMS The surveyor observed electrical boxes with covers in the basement, upstairs corridor near the	0 780		

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0 780	Continued From page 8 basement door and in some of the resident sleeping rooms where existing hardwired smoke alarms (receiving power from the building electrical system) were replaced with battery only powered smoke alarms and interconnected with additional battery powered alarms. Existing hardwired smoke alarms that are replaced are required to be maintained as hardwired in accordance with MSFC in Minnesota Rules Chapter 7511. OBSTRUCTIONS TO EGRESS The surveyor observed desks and chairs obstructing the means of egress in the corridor containing the facility offices. The marked means of egress is required to be kept clear of obstructions that impede the full and immediate use of the exit in the event of a fire or similar emergency. COMMERCIAL KITCHEN HOOD CLEANING The surveyor observed there was not documentation available indicating the commercial kitchen hood and duct system was periodically cleaned as required in MSFC in Minnesota Rules Chapter 7511. EXIT/ EMERGENCY LIGHTING The combination exit sign emergency light in the corridor outside the kitchen was tested and did not function as required to provide backup power for lighting of the corridor and exit sign in the event of a power outage. ELECTRICAL BOX COVERS	0 780		

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0 780	Continued From page 9 The surveyor observed an electrical junction box with the cover missing in the room with the pop machine. Electrical boxes containing electrical connections are required to be provided with a cover. These deficient conditions were visually verified by LALD-A, and CNS-B, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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) staff 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) Staff 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.	0 810		

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0 810	Continued From page 10 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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 observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly 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 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 January 8, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A, and clinical nurse supervisor (CNS)-B, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 11 FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on January 8, 2025, at 11:00 a.m., LALD-A, and CNS-B, stated resident procedures to take in the event of a fire or similar emergency were not included in writing in the FSEP. LALD-A, and CNS-B, also stated resident evacuation status/ unique needs for evacuation for each resident was not readily available but was kept on computer software. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01890		

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01890	Continued From page 12 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 monitor for expired medications for one of three resdients (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 7, 2025, at 1:40 p.m., the surveyor, along with clinical nurse supervisor (CNS)-B observed the medication cabinet. The surveyor found R4's Restasis eye drops to have expired on December 31, 2024. R4's record included an order for cyclosporine (Restasis) eye drops 0.05% to instill one drop into each eye twice daily. R4's record included the medication administration record for January, 2025, which indicated R4 had received these eye drops twice daily from January 1, 2025 through January 6, 2025, and the morning of January 7, 2025. On January 7, 2025, at 2:10 p.m., CNS-B stated the Restasis eye drops are expired, they just got them from the pharmacy on December 19, 2024,	01890		

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01890	Continued From page 13 and did not realize they would expire in 12 days. CNS further stated the unlicensed personnel (ULP)s administering the eye drops should have been checking the expiration date. The licensee's undated Storage of Medications policy indicated the CNS will establish a system that addresses the storage and handling of medications, including how refills and prescriptions renewals will be monitored. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all	02040		

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02040	Continued From page 14 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) 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 of available documentation and interview were conducted January 8, 2025, at 10:00 a.m., with licensed assisted living director (LALD)-A, and clinical nurse supervisor (CNS)-B, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During an interview on January 8, 2025, at 11:15 a.m., LALD-A, and CNS-B, stated an HVA had not been performed and documented on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/06/25*
Time: 13:00:00
Report: 1025251002

Food and Beverage Establishment Inspection Report

Location:
Windy Acres Long Term Care Inc
7040 Lake Boulevard
Forest Lake, MN55025
Chisago County, 13

Establishment Info:
ID #: 0038689
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6514648337
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.

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

Discussed equipment and MN 4626.0506

Facility serves TCS for multi-day service. For freezer replacement, any durable freezer which maintains TCS foods in a frozen state can be used if it's kept clean and can be moved for cleaning underneath, similar with the microwave. Coolers and other cooking/heating/temperature holding equipment are specifically called out as requiring equipment certification, however.

Blenders/grinders/slicers are called out as needing equipment certification. As for electric and stand mixers – go by the attachments on these pieces of equipment. They're functionally "electric whisks", if the attachments meet the requirements of 4626.0506.E and meet the same expectations for cleanability as a regular hand whisk, then they should be suitable for use in the kitchen. The metal attachments should be a contiguous piece (no fastenerrs or grooves). Send spec sheets or questions to my email.

Type: Full
Date: *01/06/25*
Time: 13:00:00
Report: 1025251002
Windy Acres Long Term Care Inc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025251002 of 01/06/25.

Certified Food Protection Manager: Arianna Hanson

Certification Number: 96057 Expires: 09/12/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us