



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 2, 2026

Administrator
Prairie View Senior Living
250 FIFTH STREET EAST
TRACY, MN 56175

RE: CCN:245371

Cycle Start Date: May 20, 2026

Dear Administrator:

On May 20, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed.

Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by August 20, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 20, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an

ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens

State Fire Safety Supervisor

Health Care & Correctional Facilities

MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145

St. Paul, MN 55101

Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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June 2, 2026

Administrator
Prairie View Senior Living
250 Fifth Street East
Tracy, MN 56175

Re: State Nursing Home Licensing Orders
Event ID: 22E0B1-H1

Dear Administrator:

The above facility survey was completed on May 20, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive style with a large initial 'K'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245371		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2026		
NAME OF PROVIDER OR SUPPLIER Prairie View Senior Living				STREET ADDRESS, CITY, STATE, ZIP CODE 250 FIFTH STREET EAST , TRACY, Minnesota, 56175				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 5/18/26 through 5/20/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			06/09/2026	
F0000	INITIAL COMMENTS On 5/18/26 through 5/20/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53712323 (2747303) and H53712325 (2729378). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000				06/09/2026
F0880 SS = F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)			F0880				
					1. In Continuing Compliance with F880, Infection Control and Prevention, Prairie View Senior Living corrected the deficiency by the Executive Director educating the Infection Preventionist on the Accura		06/11/2026	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0880 SS = F	Continued from page 1 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit			F0880	Continued from page 1 General Infection Prevention and Control – Surveillance Policy and ensuring surveillance of staff illness for preventing, monitoring and investigating illnesses to control infections is completed by 6/08/2026. RN-A was educated on the requirement to ensure all resident nebulizer apparatuses are disassembled, cleaned, and rinsed prior to each use by the Director of Nursing on 6/5/2026. All mechanical lifts including pedals were cleaned by housekeeping on 5/20/2026. 2. To ensure the deficiency does not recur the Accura Employee Absenteeism Report form will be implemented on 6/9/2026. All department heads and licensed nurses will be educated on the Accura Employee Absenteeism Report form by the Director of Nursing by 6/10/2026. On 5/20/2026 baskets were ordered to place nebulizers in after use to dry between treatments. All licensed nurses and TMA's will be educated by the Director of Nursing by 6/10/2026 on the requirement for nebulizer apparatuses to be disconnected, disassembled, rinsed, and left to air dry between use in designated baskets. All licensed' nurses and certified nursing assistants will be educated by the Director of Nursing by 6/10/2026 on the requirement to clean mechanical lifts between use. The Director of Nursing Services and/or designee will audit the surveillance line list for staff illnesses weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit rinsing and drying of nebulizers twice weekly for 4 weeks, weekly for 8 weeks, and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit mechanical lift cleaning twice weekly for 4 weeks, weekly for 8 weeks, and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.		06/11/2026

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F0880 SS = F	Continued from page 2 the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to facility failed to maintain surveillance of staff illness for preventing, monitoring and investigating illnesses to control infections for 1 of 1 infection control program. This had the potential to affect all 41 residents. The facility also failed to appropriately clean, rinse, and air-dry nebulizer apparatuses (mask, cup) after medication administration for 3 of 3 residents (R9, R14 and R21) and ensure 3 of 3 observed stand lifts, located in the 200 and 300 wing were appropriately cleaned between resident use. Findings include: SURVIELLANCE Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at, https://www.health.state.mn.us/diseases/foodborn e/outbreak/facility/ltcfnorotoolkit.pdf, identified Norovirus is transmitted through a fecal (stool)-oral route with symptoms of diarrhea, vomiting, nausea, abdominal pain, low grade fever, headache, and or body aches. Individuals generally become ill 12-48 hours after exposure (swallowing Norovirus). Infected individuals shed the virus in their stool and contaminate food, surfaces, and objects and can be shed in the stool for several weeks after recovery. Products used to clean Norovirus must say they are effective against Norovirus. Hand sanitizer does not			F0880			06/11/2026

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F0880 SS = F	Continued from page 3 work to kill the virus. Individuals should wash their hands for 20 seconds with soap and water. Individual cases of Norovirus are not reportable to the State, however, possible outbreaks or multiple cases with Norovirus-like symptoms must be reported. Documentation of possible outbreaks was to include: Use the RESIDENT ILLNESS LOG and STAFF ILLNESS LOG to document illnesses among staff and residents/patients: Contact managers of each unit, etc. as necessary to gather illness information. Send both ILLNESS LOGS back to MDH within 2 business days of reporting the suspected outbreak. Epidemiology staff will use this to assess A) which pathogen is causing the outbreak, B) the likely route of transmission, and C) whether additional prevention measures are needed. Gather additional information List activities, events, etc., held during the week prior to the first illness (especially if food was served). Determine when and where there were any vomiting incidents or diarrheal accidents in the facility. If requested by MDH, provide a dietary menu (breakfast, lunch, and dinner). If requested by MDH, provide names and phone numbers for staff and/or residents (in rare cases, MDH may want to conduct interviews). Collect a stool sample from three (3) residents and/or staff and send to MDH Laboratory for analysis (MDH will provide specimen collection kits; the testing is free of charge). If stools from residents or staff were sent to a clinical laboratory, notify MDH of any results. Send both completed ILLNESS LOGS back to MDH			F0880			06/11/2026

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F0880 SS = F	Continued from page 4 between 1 and 2 weeks after the last illness. IMPLEMENT OUTBREAK CONTROL MEASURES: Monitor for resident illness (record on RESIDENT ILLNESS LOG) and when possible, isolate residents while they are ill and for 72 hours after symptoms have stopped. Consider halting new admissions until the outbreak has ended. Exclude actively ill residents from games/activities where touching common items occurs (e.g., checkers, cards). Monitor for staff illness (record on STAFF ILLNESS LOG) and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended. Review of the Attendance Slip forms identified columns of: Employee name Shift and date Excuse for calling in Time called in A check box if staff were late (approved with less than 12-hour notice), late (no notice), 2 plus hours late (without notice) and if checked, how late staff were, if they left work early without approval, were a no-show, and who it was completed by. The form had no column to document when symptoms started, when symptoms were resolved, when staff RTW, or if they were cleared using national/ state standards to return to work. Review of May 2026, Attendance Slips identified: NA-B had called in on 5/2/26, with symptoms of nausea and vomiting. Review of NA-B time punch identified NA-B had returned to work on 5/3/26 the			F0880			06/11/2026

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F0880 SS = F	Continued from page 5 next day. NA-A had called in on 5/18/26, with symptoms of vomiting and fever. Review of NA-A time punch identified NA-A had returned to work on 5/19/26 the next day. Interview on 5/19/26 at 4:15 p.m., with the infection preventionist (IP) identified she did not have surveillance for staff illnesses. If staff called in one day for a headache, vomiting, diarrhea, or fever they were allowed to return to work 24 hours after symptoms resolved. For norovirus, the facility “just kept track of symptoms” and if they were symptomatic and more than one resident or staff was affected, that would constitute an outbreak then she would track that information and keep the resident in their room. She made no mention of how that would affect a staff’s RTW. When a staff member called in, the person taking the call would fill out an attendance slip. The attendance slip typically went to the director of nursing (DON). She was unaware that staff should be out for 72 hours with symptoms of potential norovirus per State guidance. She acknowledged that she had not tracked staff illness since January of 2025. Interview on 5/19/26 at 4:28 p.m., with the administrator identified the facility could not require staff to disclose their symptoms or reason for calling in if the staff did not voluntarily provide that information. Interview on 5/20/26 at 11:32 a.m., with nursing assistant (NA)-A identified she had called-in for work on 5/18/26, she had vomited and had a fever Friday night on 5/15/26. She had called in because her stomach still did not “feel good”. She was unaware of any process for staff when they were ill. She had just called in ill and felt better the next day and assumed she should be able to RTW. She thought there should be some kind of process to ensure the residents do not become ill also. Interview on 5/20/26 at 11:52 a.m., with infection preventionist (IP) identified she reached out to her registered nurse (RN) consultant for the facility and was informed that there was no RTW policy. RTW was dependent on the staff symptoms. If staff had one day of vomiting but felt better the next day, staff would be allowed to RTW. The facility was to track			F0880			06/11/2026

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F0880 SS = F	Continued from page 6 symptoms on the absentee form the facility used. She did not receive the forms; however, she was notified of staff illnesses verbally. Staff are asked to report their symptoms when calling in for a shift, however they were not required to disclose their symptoms if they did not want to. Review of 4/20/26, General Infection Prevention and Control-Surveillance policy identified the infection preventionist would record infection data on the facilities monthly Infection Line Listing/Log in Infection Watch. Infection Control Records would be reviewed, presented, and evaluated by the QAPI Committee quarterly for residents and staff. Review of 4/20/26, Surveillance and Monitoring policy identified the facility would maintain routine surveillance and monitoring of the workplace. The infection preventionist or the director of nursing would be responsible for maintaining the surveillance records. The surveillance record would be evaluated for corrective measures to be taken to prevent a recurrence or similar exposure. The surveillance and monitoring would be reviewed at the QAPI meetings. Review of 4/20/26, Staff with Infections policy identified the facility would evaluate staff with infection to determine if staff may continue providing direct care or services to residents in the facility. Staff with infections would not be permitted to provide direct care until the facility conducted a review of the staff's medical record to determine if the staff may provide direct care in accordance with the established policies. NEBS Observations during initial tour on 5/18/26 beginning at 10:00 a.m., through 11:00 a.m., identified R9, R14, and R21's nebulizers were lying on their bedside tables/ nightstands and had not been disconnected, rinsed and air dried. Additional observation and interview on 5/18/26 at 3:48 p.m. of registered nurse (RN)-A as she proceeded to give R9 her inhaled nebulizer treatment identified R9's medication apparatus was still intact from this morning's administration. RN-A proceeded to hold the nebulizer and pour the nebulizer medication from the ampule in through the mask			F0880			06/11/2026

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F0880 SS = F	Continued from page 7 and into the medication cup. RN-A stated the apparatus should have been disassembled, cleaned and rinsed after each nebulizer administration. She was unsure if this occurred and noted facility policy directs staff to disassemble, clean, and air dry after each medication observation. Review of the May 2026 Medication Administration/Treatment Administration Records (MAR/TAR) identified: R9 had received her 6:00 a.m., nebulizer treatment for formoterol furmate nebulizer treatment solution that morning. R21 had received her ipratropium-albuterol inhaler nebulizer treatment at 7:00 a.m. that morning. Review of the 4/20/26, Respiratory Equipment Cleaning Procedure policy identified after each use, staff were to rinse the mouthpiece and medication cup with water and allow to air dry. MECHANICAL LIFTS Random observations on 5/18/26 from 10:00 a.m., through 6:00 p.m., of the 200 and 300 wing stand lifts identified all 3 lifts were sitting in the hall waiting to be used and had dirt and food-like debris on the pedals. Interview on 5/20/26 at 2:02 p.m. with RN-A identified stand lifts were to be cleaned after each use. Review of the 4/20/26, Nursing Weekly Cleaning task policy identified multiple use items, such as a mechanical lift were to be cleaned and disinfected after each use.			F0880			06/11/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living			F0584	1. In Continuing Compliance with F584, Safe/Clean/Comfortable/Homelike Environment, Prairie View Senior Living corrected the deficiency by having maintenance paint all chipped/scratched paint on the walls in R36 room on 5/20/2026. All other resident rooms were audited by maintenance and all chipped/scratched paint on walls were painted on 5/20/2026.		06/09/2026

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F0584 SS = D	Continued from page 8 safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident's (R36) room was maintained in a homelike manner and ensure preventative maintenance was provided to repair numerous chips and scratches in the pain on 2 of 4 walls. Findings include:			F0584	Continued from page 8 2. To ensure the deficiency does not recur, Maintenance was educated on 6/3/206 to complete a monthly visual inspection of each resident room to ensure a safe, clean, homelike environment and to repair any identified concerns. Maintenance will complete an inspection tool to document that each resident room is inspected monthly to ensure a safe and clean environment. The Executive Director and/or designee will audit monthly for 3 months and then randomly to ensure the inspection tool is completed. 3. As part of Prairie View Senior Living's commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		06/09/2026

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F0584 SS = D	Continued from page 9 R36's comprehensive Minimum Data Set (MDS), accepted on 9/5/25, identified R36 was re-admitted to the facility in November 2023, with diagnoses of heart failure, high blood pressure, and arthritis. R36 had intact cognition and had no behaviors noted. Observation on 5/18/25 at 10:25 a.m., of R36 ion her room identified R36 was seated in her chair. R36 was alert and oriented and stated she had been at the facility for “a while”. R36 had numerous chips on the walls directly behind her chair and on the right side of the bed, approximately 10 to 12 inches on the wall, above the mattress. When asked about the chips and scuffs in the paint, R36 stated they had “always been there” since she moved in. Interview on 5/20/26 at 1:00 p.m., with the administrator identified the maintenance director (M-D) was out at the moment, but he did use a TELS system that could generate, assign, and track work orders, and could be used to track preventative maintenance. He was unsure if the M-D had a preventative maintenance schedule that included resident rooms, but agreed at a minimum, rooms should be checked yearly for maintenance needs. He noted R36 did like to move her furniture around a lot. Interview on 5/20/26 at 1:38 p.m., with registered nurse (RN)-A identified R36 was known to move things around in her room. RN-A was unaware of the numerous scratches and chips in R36's pain behind her chair and beside her bed on the wall. She was not sure if staff had put in a work ticket but did think the M-D did do environmental rounds. Review of the QAPI meeting minutes from May 2025 through April 2026 identified M-D was present at the QAPI meetings and submitted data for environmental services that included painting as needed in the category of Building Improvements. The action plans were to touch up paint when rooms were empty or as needed. Review of the 4/26/26 Safety Meeting documentation identified facility staff did perform monthly safety rounds; however, there was no mention of specific preventative maintenance checks to ensure resident rooms were maintained in a homelike manner.			F0584			06/09/2026

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F0584 SS = D	Continued from page 10 There was no policy related to preventative maintenance provided by the end of survey.			F0584			06/09/2026
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.			F0849	1. In Continuing Compliance with F849, Hospice Services, Prairie View Senior Living corrected the deficiency by retaining and uploading all hospice notes to the medical record for R5 and all other hospice residents. The Director of Nursing was educated on ensuring licensed nurses are documenting all hospice communication in the medical record by the Executive Director on 6/9/2026. 2. To ensure the deficiency does not recur all licensed nurses were educated by the Director of Nursing on ensuring all hospice communication is documented in the medical record by 6/10/26. The facility requested access to Avera Chart Link on 6/9/2026 and our facility medical records will ensure all hospice visit notes are retained and uploaded to the medical record after each visit once access is granted. Until access is granted hospice nurse will email visit notes to facility staff to upload to resident EMR. On 6/5/2026 each hospice provider was communicated to on the requirement to communicate with the facility charge nurses regarding their visit prior to leaving follow a visit with a patient. The Director of Nursing and/or designee will audit hospice communication documentation in PCC weekly for 12 weeks and then randomly to ensure continued compliance. The Director of Nursing and/or designee will audit hospice resident medical records for hospice visit notes weekly for 12 weeks and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the DON and/or designee will report identified concerns through the community's QA Process.		06/11/2026

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F0849 SS = D	Continued from page 11 (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.			F0849			06/11/2026

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F0849 SS = D	Continued from page 12 (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system.			F0849			06/11/2026

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F0849 SS = D	Continued from page 13 (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to have documented communication between the facility and hospice per their written agreement and ensure hospice notes were included in the medical record for 1 of 1 sampled hospice resident (R5). Findings include: R5's comprehensive Minimum Data Set (MDS) assessment, accepted on 9/24/25 identified R5 was re-admitted to the facility in September 2024, with diagnoses of dementia, anxiety disorder and had moderately impaired cognition. R5's current, undated care plan identified R5 has a terminal prognosis requiring hospice involvement/palliative care related to his end stage disease process. Comfort, dignity and autonomy was to be maintained at the highest level and was to demonstrate peacefulness and calmness through body language and/or verbalization. Review of R5's electronic medical record (EMR) hospice notes identified R5's R5 had hospice notes, schedules, and care plans captured in the EMR for the following months: February 2025, 9 times.			F0849			06/11/2026

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F0849 SS = D	Continued from page 14 March 2025, 6 times. April 2025, 5 times. May 2025, 1 time. June 2025 through August 2025, no notes were captured. September 2025, 6 times. October 2025 through February 2026, no notes were captured. March 2026, 5 times. April 2026, no notes were captured. May 2026, 7 times. Interview on 5/20/26 at 8:46 a.m., with the hospice nurse (HN)-A identified he or another nurse would come to the facility 2x per week on Tuesdays and Fridays. The facility was supposed to have all documentation from each hospice visit captured in their medical record. He noted very recently he had some issues faxing over the documents, but that had been resolved. Hospice staff always speak to facility staff and give report after each day they visit. He was unsure why the facility didn't have any notes and wasn't aware they were missing any. R5's 5/1/26 current hospice care plan identified he was admitted to hospice for senile degeneration of the brain. R5's hospice visit communication note from the facility identified there was 1 entry in January 2025, made by registered nurse (RN)-A that noted R5 continued to have an ulcer to his left rear calf. Improvement was noted. R5 also had a pressure ulcer to his right heel. Staff were to ask the physician to continue betadine and noted other interventions. There was no mention if this was a recommendation from hospice, or what the communication was that day between hospice and the facility staff. Interview and document review on 5/20/26 at 1:26 p.m., with RN-A identified she would expect the facility to follow the hospice contract made between			F0849			06/11/2026

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F0849 SS = D	Continued from page 15 R5's hospice and the facility. Staff do have verbal communication, but the facility doesn't document that communication. If the staff that received the verbal communication and did not pass along pertinent information, she agreed communication that may be urgent etc. could be lost. She was unaware the hospice notes were not being captured for several months. Hospice was to send the administrator the notes, and he would print them out and give them to staff. She was not aware of anyone else checking to see the facility had received that documentation and agreed they need to follow contract identifying both parties document communication. Review of the current hospice contract between R5's hospice provider and the facility identified hospice, and the facility, were to communicate with one another regularly and as needed. After every communication, each party was to document the communication in its respective clinical records to ensure the needs of hospice patients were met 24 hours per day.			F0849			06/11/2026
F0949 SS = D	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 8 sampled staff (director of nursing (DON) and nursing assistant (NA)-C) had initial or annual Alzheimer's and dementia training. Findings include: Review of the facility Employee Roster, Job and hire date document identified nursing assistant (NA)-C's had a hire date of 2/23/26. Review of her Alzheimer's Disease or Related Disorder Training identified she had not completed training for an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, or communication skills.			F0949	1. In Continuing Compliance with F949, Behavioral Health Training, Prairie View Senior Living corrected the deficiency by the Director of Nursing completing dementia training on May 26, 2026, for NA-C after 6/12/2026 is dementia training is not completed she will be removed from the schedule until completion. All other employees with past due dementia training will have training completed by 6/12/2026 or will be removed from schedule until completed. 2. To ensure the deficiency does not recur the Executive Director was educated by the Accura Regional Clinical Specialist on the employee behavioral training requirements on 6/5/2026. The Executive Director and/or designee will audit employee dementia training monthly for 3 months and then randomly to ensure continued compliance. 3. As part of Prairie View Senior Living's commitment to quality assurance, the ED and/or designee will report identified concerns through the community's QA Process.		

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F0949 SS = D	Continued from page 16 Review of the facility Employee Roster, Job and hire date document identified director of nursing (DON) had a hire date of 5/28/24. Review of her Alzheimer's Disease or Related Disorder Training identified she had not completed training for an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, or communication skills. Interview on 5/19/26 at 4:25 p.m., with the administrator identified that 2 of the 8 staff had not completed their Alzheimer's training as required. He would expect the Alzheimer's training to be completed initially and annually as required. Review of the undated, New Hire Requirements for Relias orientation education included dementia care: Understanding the world of dementia Being with a person with dementia, listening and speaking Being with a person with dementia, actions and reactions Alzheimer's/Dementia verses normal ageing Helping friends and family with dementia care Preventing adverse reactions to dementia care Dementia care, performing ADL's Dementia care, challenging behaviors and direct care staff Caregiver stress management Review of the 5/12/26, Facility Assessment identified staffing would be adequate for caring for residents with mental health conditions, history of trauma and dementia. The facilities training program for new and existing staff included dementia management and abuse prevention, effective communication, special needs of residents, and caring for residents who are cognitively impaired. A policy on the facilities Alzheimer's dementia training program for new hires and annual training was requested but not provided.			F0949			06/11/2026

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/18/26 through 5/20/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed: H53712323			20000			06/10/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2026	
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20000	Continued from page 1 (2747303) and H53712325 (2729378). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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/RULES.		20000			06/10/2026	
20302	Alzheimer's disease or related disorder train CFR(s): MN State Statute 144.6503 ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503		20302	Corrected		06/09/2026	

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20302	Continued from page 2 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 8 sampled staff (director of nursing (DON) and nursing assistant (NA)-C) had initial or annual Alzheimer's and dementia training. Findings include: Review of the facility Employee Roster, Job and hire date document identified nursing assistant (NA)-C's had a hire date of 2/23/26. Review of her Alzheimer's Disease or Related Disorder Training identified she had not completed training for an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, or communication skills. Review of the facility Employee Roster, Job and hire			20302			06/09/2026

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20302	Continued from page 3 date document identified director of nursing (DON) had a hire date of 5/28/24. Review of her Alzheimer's Disease or Related Disorder Training identified she had not completed training for an explanation of Alzheimer's disease and related disorders, assistance with activities of daily living, problem solving with challenging behaviors, or communication skills. Interview on 5/19/26 at 4:25 p.m., with the administrator identified that 2 of the 8 staff had not completed their Alzheimer's training as required. He would expect the Alzheimer's training to be completed initially and annually as required. Review of the undated, New Hire Requirements for Relias orientation education included dementia care: Understanding the world of dementia Being with a person with dementia, listening and speaking Being with a person with dementia, actions and reactions Alzheimer's/Dementia verses normal ageing Helping friends and family with dementia care Preventing adverse reactions to dementia care Dementia care, performing ADL's Dementia care, challenging behaviors and direct care staff Caregiver stress management Review of the 5/12/26, Facility Assessment identified staffing would be adequate for caring for residents with mental health conditions, history of trauma and dementia. The facilities training program for new and existing staff included dementia management and abuse prevention, effective communication, special needs of residents, and caring for residents who are cognitively impaired. A policy on the facilities Alzheimer's dementia training program for new hires and annual training was requested but not provided.			20302			06/09/2026

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20302	Continued from page 4 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee should review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The administrator, director of nursing, or designee should develop a system to educate staff and develop a monitoring system to ensure compliance as directed by the written plan of care. The facility should report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations and ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.		20302				
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to facility failed to maintain surveillance of staff illness for preventing, monitoring and investigating illnesses to control infections for 1 of 1 infection control program. This had the potential to affect all 41 residents. The facility also failed to appropriately clean, rinse, and air-dry nebulizer apparatuses (mask, cup) after medication administration for 3 of 3 residents (R9, R14 and R21) and ensure 3 of 3 observed stand lifts, located in the 200 and 300 wing were appropriately cleaned between resident use. Findings include: SURVIELLANCE Review of the 2024-2025 Norovirus Information for Long-term Care Facilities, located at, https://www.health.state.mn.us/diseases/foodborn		21375	Corrected		06/11/2026	

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21375	Continued from page 5 e/outbreak/facility/ltcfnorotoolkit.pdf, identified Norovirus is transmitted through a fecal (stool)-oral route with symptoms of diarrhea, vomiting, nausea, abdominal pain, low grade fever, headache, and or body aches. Individuals generally become ill 12-48 hours after exposure (swallowing Norovirus). Infected individuals shed the virus in their stool and contaminate food, surfaces, and objects and can be shed in the stool for several weeks after recovery. Products used to clean Norovirus must say they are effective against Norovirus. Hand sanitizer does not work to kill the virus. Individuals should wash their hands for 20 seconds with soap and water. Individual cases of Norovirus are not reportable to the State, however, possible outbreaks or multiple cases with Norovirus-like symptoms must be reported. Documentation of possible outbreaks was to include: Use the RESIDENT ILLNESS LOG and STAFF ILLNESS LOG to document illnesses among staff and residents/patients: Contact managers of each unit, etc. as necessary to gather illness information. Send both ILLNESS LOGS back to MDH within 2 business days of reporting the suspected outbreak. Epidemiology staff will use this to assess A) which pathogen is causing the outbreak, B) the likely route of transmission, and C) whether additional prevention measures are needed. Gather additional information List activities, events, etc., held during the week prior to the first illness (especially if food was served). Determine when and where there were any vomiting incidents or diarrheal accidents in the facility. If requested by MDH, provide a dietary menu (breakfast, lunch, and dinner). If requested by MDH, provide names and phone numbers for staff and/or residents (in rare cases, MDH may want to conduct interviews). Collect a stool sample from three (3) residents and/or staff and send to MDH Laboratory for analysis (MDH will provide specimen collection kits; the testing is free of charge). If stools from residents or staff were sent to a clinical laboratory, notify MDH			21375			06/11/2026

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21375	Continued from page 6 of any results. Send both completed ILLNESS LOGS back to MDH between 1 and 2 weeks after the last illness. IMPLEMENT OUTBREAK CONTROL MEASURES: Monitor for resident illness (record on RESIDENT ILLNESS LOG) and when possible, isolate residents while they are ill and for 72 hours after symptoms have stopped. Consider halting new admissions until the outbreak has ended. Exclude actively ill residents from games/activities where touching common items occurs (e.g., checkers, cards). Monitor for staff illness (record on STAFF ILLNESS LOG) and restrict ill staff/volunteers from patient care and food handling duties until 72 hours after their vomiting/diarrhea has ended. Review of the Attendance Slip forms identified columns of: Employee name Shift and date Excuse for calling in Time called in A check box if staff were late (approved with less than 12-hour notice), late (no notice), 2 plus hours late (without notice) and if checked, how late staff were, if they left work early without approval, were a no-show, and who it was completed by. The form had no column to document when symptoms started, when symptoms were resolved, when staff RTW, or if they were cleared using national/ state standards to return to work. Review of May 2026, Attendance Slips identified: NA-B had called in on 5/2/26, with symptoms of nausea and vomiting. Review of NA-B time punch identified NA-B had returned to work on 5/3/26 the next day. NA-A had called in on 5/18/26, with symptoms of vomiting and fever. Review of NA-A time punch identified NA-A had returned to work on 5/19/26 the next day.			21375			06/11/2026

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21375	Continued from page 7 Interview on 5/19/26 at 4:15 p.m., with the infection preventionist (IP) identified she did not have surveillance for staff illnesses. If staff called in one day for a headache, vomiting, diarrhea, or fever they were allowed to return to work 24 hours after symptoms resolved. For norovirus, the facility “just kept track of symptoms” and if they were symptomatic and more than one resident or staff was affected, that would constitute an outbreak then she would track that information and keep the resident in their room. She made no mention of how that would affect a staff’s RTW. When a staff member called in, the person taking the call would fill out an attendance slip. The attendance slip typically went to the director of nursing (DON). She was unaware that staff should be out for 72 hours with symptoms of potential norovirus per State guidance. She acknowledged that she had not tracked staff illness since January of 2025. Interview on 5/19/26 at 4:28 p.m., with the administrator identified the facility could not require staff to disclose their symptoms or reason for calling in if the staff did not voluntarily provide that information. Interview on 5/20/26 at 11:32 a.m., with nursing assistant (NA)-A identified she had called-in for work on 5/18/26, she had vomited and had a fever Friday night on 5/15/26. She had called in because her stomach still did not “feel good”. She was unaware of any process for staff when they were ill. She had just called in ill and felt better the next day and assumed she should be able to RTW. She thought there should be some kind of process to ensure the residents do not become ill also. Interview on 5/20/26 at 11:52 a.m., with infection preventionist (IP) identified she reached out to her registered nurse (RN) consultant for the facility and was informed that there was no RTW policy. RTW was dependent on the staff symptoms. If staff had one day of vomiting but felt better the next day, staff would be allowed to RTW. The facility was to track symptoms on the absentee form the facility used. She did not receive the forms; however, she was notified of staff illnesses verbally. Staff are asked to report their symptoms when calling in for a shift, however they were not required to disclose their symptoms if they did not want to.			21375			06/11/2026

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21375	Continued from page 8 Review of 4/20/26, General Infection Prevention and Control-Surveillance policy identified the infection preventionist would record infection data on the facilities monthly Infection Line Listing/Log in Infection Watch. Infection Control Records would be reviewed, presented, and evaluated by the QAPI Committee quarterly for residents and staff. Review of 4/20/26, Surveillance and Monitoring policy identified the facility would maintain routine surveillance and monitoring of the workplace. The infection preventionist or the director of nursing would be responsible for maintaining the surveillance records. The surveillance record would be evaluated for corrective measures to be taken to prevent a recurrence or similar exposure. The surveillance and monitoring would be reviewed at the QAPI meetings. Review of 4/20/26, Staff with Infections policy identified the facility would evaluate staff with infection to determine if staff may continue providing direct care or services to residents in the facility. Staff with infections would not be permitted to provide direct care until the facility conducted a review of the staff's medical record to determine if the staff may provide direct care in accordance with the established policies. NEBS Observations during initial tour on 5/18/26 beginning at 10:00 a.m., through 11:00 a.m., identified R9, R14, and R21's nebulizers were lying on their bedside tables/ nightstands and had not been disconnected, rinsed and air dried. Additional observation and interview on 5/18/26 at 3:48 p.m. of registered nurse (RN)-A as she proceeded to give R9 her inhaled nebulizer treatment identified R9's medication apparatus was still intact from this morning's administration. RN-A proceeded to hold the nebulizer and pour the nebulizer medication from the ampule in through the mask and into the medication cup. RN-A stated the apparatus should have been disassembled, cleaned and rinsed after each nebulizer administration. She was unsure if this occurred and noted facility policy directs staff to disassemble, clean, and air dry after each medication observation.			21375			06/11/2026

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21375	Continued from page 9 Review of the May 2026 Medication Administration/Treatment Administration Records (MAR/TAR) identified: R9 had received her 6:00 a.m., nebulizer treatment for formoterol furmate nebulizer treatment solution that morning. R21 had received her ipratropium-albuterol inhaler nebulizer treatment at 7:00 a.m. that morning. Review of the 4/20/26, Respiratory Equipment Cleaning Procedure policy identified after each use, staff were to rinse the mouthpiece and medication cup with water and allow to air dry. MECHANICAL LIFTS Random observations on 5/18/26 from 10:00 a.m., through 6:00 p.m., of the 200 and 300 wing stand lifts identified all 3 lifts were sitting in the hall waiting to be used and had dirt and food-like debris on the pedals. Interview on 5/20/26 at 2:02 p.m. with RN-A identified stand lifts were to be cleaned after each use. Review of the 4/20/26, Nursing Weekly Cleaning task policy identified multiple use items, such as a mechanical lift were to be cleaned and disinfected after each use. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure employees are monitored for illness and measures are placed to identify when an appropriate return to work may occur. The DON or designee could educate all staff on existing or revised policies and perform measurable audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Additionally, the DON (Director of Nursing) or designee should review/revise facility policies to ensure nebulizer equipment and mechanical lifts are developed and/or implemented and educate all staff on existing or revised policies and perform measurable audits to			21375			06/11/2026

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21375	Continued from page 10 ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.		21375			06/11/2026	
21695	Plant Housekeeping, Operation, & Maintenance CFR(s): MN Rule 4658.1415 Subp. 4 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident's (R36) room was maintained in a homelike manner and ensure preventative maintenance was provided to repair numerous chips and scratches in the pain on 2 of 4 walls. Findings include: R36's comprehensive Minimum Data Set (MDS), accepted on 9/5/25, identified R36 was re-admitted to the facility in November 2023, with diagnoses of heart failure, high blood pressure, and arthritis. R36 had intact cognition and had no behaviors noted. Observation on 5/18/25 at 10:25 a.m., of R36 ion her room identified R36 was seated in her chair. R36 was alert and oriented and stated she had been at the facility for "a while". R36 had numerous chips on the walls directly behind her chair and on the right side of the bed, approximately 10 to 12 inches on the wall, above the mattress. When asked about the chips and scuffs in the paint, R36 stated they had "always been there" since she moved in. Interview on 5/20/26 at 1:00 p.m., with the administrator identified the maintenance director (M-D) was out at the moment, but he did use a TELS system that could generate, assign, and track work orders, and could be used to track preventative		21695	Corrected		06/11/2026	

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21695	Continued from page 11 maintenance. He was unsure if the M-D had a preventative maintenance schedule that included resident rooms, but agreed at a minimum, rooms should be checked yearly for maintenance needs. He noted R36 did like to move her furniture around a lot. Interview on 5/20/26 at 1:38 p.m., with registered nurse (RN)-A identified R36 was known to move things around in her room. RN-A was unaware of the numerous scratches and chips in R36's pain behind her chair and beside her bed on the wall. She was not sure if staff had put in a work ticket but did think the M-D did do environmental rounds. Review of the QAPI meeting minutes from May 2025 through April 2026 identified M-D was present at the QAPI meetings and submitted data for environmental services that included painting as needed in the category of Building Improvements. The action plans were to touch up paint when rooms were empty or as needed. Review of the 4/26/26 Safety Meeting documentation identified facility staff did perform monthly safety rounds; however, there was no mention of specific preventative maintenance checks to ensure resident rooms were maintained in a homelike manner. There was no policy related to preventative maintenance provided by the end of survey. SUGGESTED METHOD OF CORRECTION: The administrator or designee should identify how it will maintain a homelike environment and ensure the facility have written policies and procedures developed and implemented. The facility should describe the procedures for maintaining and providing preventative maintenance in order to provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. The facility should educate staff who are responsible for reporting needed repairs and those in charge of maintenance and perform monthly routine environmental rounds. The facility should then perform measurable audits to ensure all are adhering to the policy. The results of those audits should be taken to QAPI to determine compliance or the need for further monitoring.			21695			06/11/2026

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NAME OF PROVIDER OR SUPPLIER Prairie View Senior Living				STREET ADDRESS, CITY, STATE, ZIP CODE 250 FIFTH STREET EAST , TRACY, Minnesota, 56175			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
21695	Continued from page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21695			06/11/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 1, 2026

Administrator
Prairie View Senior Living
250 FIFTH STREET EAST
TRACY, MN 56175

RE: CCN: 245371
Cycle Start Date: May 20, 2026

Dear Administrator:

On June 22, 2026, the Minnesota Department of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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July 1, 2026

Administrator
Prairie View Senior Living
250 FIFTH STREET EAST
TRACY, MN 56175

Re: Reinspection Results
Event ID: 22E0B1-H2

Dear Administrator:

On June 22, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 20, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
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