Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

5/21/2026

Administrator
Prairie Manor Care Center

220 THIRD STREET NORTHWEST
BLOOMING PRAIRIE, MN 55917

RE: CCN: 245482

Cycle Start Date: May 19, 2026

Dear Administrator:

On May 19, 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The CMS-2567 is being electronically delivered.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

SURVEY TEAM WILL COMPLETE:

Standard Survey:		Extended Survey:	
From: F1 *(mm/dd/yyyy)*	To: F2 *(mm/dd/yyyy)*	From: F3 *(mm/dd/yyyy)*	To: F4 *(mm/dd/yyyy)*

GENERAL INSTRUCTIONS:

This form is to be completed by the Facility. For the purpose of this form, "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Name of Facility	Provider Number	F5: Fiscal Year Ending *(mm/dd/yyyy)*
Prairie Manor, Inc.	HFID: 00650	09/30/2026

Street Address: 220 3rd st nw

City	County	State	Zip Code
Blooming Prairie	Steele	MN	55917

F6: Telephone Number:	F7: State/County Code:	F8: State/Region Code:
507-583-4434		

F8a: Medicare	F8b: Medicaid	F8c: Other	F8d: Total Residents
4	25	7	36

F9: 03

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

F10: Is this facility hospital based? ..... ○ Yes ◉ No

If yes, indicate Hospital Provider Number: F11

F12: Ownership: 05

For-Profit	Non-Profit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal
13 Limited Liability Corporation			

F13: Owned or leased by Multi-Facility Organization ..... ○ Yes ◉ No

F14: Name of Multi-Facility Organization

Dedicated Special Care Units: *(show number of beds for all that apply)*

F15: AIDS	F16: Alzheimer's Disease	F17: Dialysis
0	0	0
F18: Disabled Children/Young Adults	**F19: Head Trauma**	**F20: Hospice**
0	0	0
F21: Huntington's Disease	**F22: Ventilator/Respiratory Care**	**F23: Other Specialized Rehabilitation**
0	0	0

F24: Does the facility currently have an organized residents' group? ..... ◉ Yes ○ No

F25: Does the facility currently have an organized group of family members of residents? ..... ○ Yes ◉ No

F26: Does the facility conduct experimental research? ..... ○ Yes ◉ No

F27: Is the facility part of a continuing care retirement community (CCRC)? ..... ○ Yes ◉ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:		**Waiver of 24 hr licensed nursing requirement:**	
F28: Date *(mm/dd/yyyy)*	F29: Hours waived per week:	F30: Date *(mm/dd/yyyy)*	F31: Hours waived per week

F32: Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? ..... ○ Yes ◉ No

Name of Person Completing Form	Time
Joseph Mason	10:45am
Signature: Joe Mason	Date: 05/18/2026

TO BE COMPLETED BY SURVEY TEAM:

1. Was ombudsman office notified prior to survey? ..... ○ Yes ○ No

2. Was ombudsman present during any portion of the survey? ..... ○ Yes ○ No

3. Medication error rate _____% (The medication error rate at the time of survey, based upon observation by the surveyor. This is a percentage. You can enter only whole numbers up to 999.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245482	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Manor Care Center	**220 THIRD STREET NORTHWEST , BLOOMING PRAIRIE, Minnesota, 55917**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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 to 5/19/26, 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		
F0000	INITIAL COMMENTS On 5/18/26 to 5/19/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be 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, the facility must acknowledge receipt of the electronic documents.	F0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245482	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Manor Care Center	**220 THIRD STREET NORTHWEST , BLOOMING PRAIRIE, Minnesota, 55917**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/20/2026. At the time of this survey, PRAIRIE MANOR CARE CENTER was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. PRAIRIE MANOR CARE CENTER is a one-story building with a partial basement. The building was constructed at (3) different times. The original building was constructed in 1970 and was determined to be of Type II (222) construction. In 1987 an addition was constructed and was determined to be of Type II (222) construction. In 1991 an addition was constructed (Chapel) and was determined to be of Type II (222) construction. Because the original building and the (2) additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors, which is monitored for automatic fire department notification. There is a 2-hour fire separation between the Skilled Nursing Facility and the Assisted Living.	K0000		

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K0000 Bldg. 01	Continued from page 1 The facility has a capacity of 36 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K0000		