Electronically Delivered

October 16, 2025

Licensee
Prairie Senior Cottages of New Ulm LLC
1304 Birchwood Drive
New Ulm, MN 56073

RE: Project Number(s) SL30771016

Dear Licensee:

On September 18, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 11, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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Electronically Delivered

August 7, 2025

Licensee
Prairie Senior Cottage of New Ulm, LLC
1304 Birchwood Drive
New Ulm, MN 56073

RE: Project Number(s) SL30771016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 11, 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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. 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 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

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.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30771	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF NEW ULM LLC	1304 BIRCHWOOD DRIVE NEW ULM, MN 56073

(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 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: SL30771016 On June 9, 2025, through June 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 14 residents; 14 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was identified on June 11, 2025, at a level 3/Widespread (I). The licensee took immediate action on June 11, 2025; however, the scope and level remains at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of three unlicensed personnel (ULP)-D. This had the potential to affect all residents, visitors, 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). The findings include: On June 10, 2025, the surveyor observed the following: -at 11:16 a.m., ULP-D prepared breakfast food without wearing gloves; -at 11:25 a.m., ULP-D prepared breakfast food	0 510		

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0 510	Continued From page 2 without wearing gloves; and -at 12:04 p.m., ULP-D touched bread without wearing gloves. ULP-D did not use proper hygiene and infection control techniques with food preparation. On June 10, 2025, at 11:30 a.m., ULP-D stated she was trained to wash hands repeatedly and gloved use was based on individual preference. On June 10, 2025, at 12:37 p.m., clinical nurse supervisor (CNS)-B stated when food prep is being completed, staff were trained and it was their policy to wear gloves. The licensee's Gloves policy dated June 9, 2023, indicated gloves are worn to prevent bare hand contact with ready to eat food during food preparation and serving. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	0 650		

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0 650	Continued From page 3 (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employee's (unlicensed personnel (ULP)-C) and clinical nurse supervisor (CNS)-B) records included the required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C was hired on May 16, 2016, to provide direct care services to the licensee's residents. On June 9, 2025, at 8:07 a.m., the surveyor observed ULP-C assist R3 with morning	0 650		

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0 650	Continued From page 4 medication administration. ULP-C's employee record included a performance review dated December 26, 2023. ULP-C's employee record did not include a current annual performance review. CNS-B CNS-B was hired on October 18, 2022, to provide supervisory and direct care services for the licensee. CNS-B's employee record did not include an annual performance review. On June 11, 2025, at 11:06 a.m., CNS-B stated ULP-C's employee record did not include a current annual performance review and CNS-B's employee record did not include an annual performance review. The licensee's Personnel Records policy dated June 1, 2023, indicated performance evaluations which identify areas of improvement needed and training needs performance reviews must be conducted at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660		

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0 660	Continued From page 5 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented for one of one unlicensed personnel (ULP-C). 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: ULP-C was hired on May 16, 2016, to provide	0 660		

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0 660	Continued From page 6 direct care services to the licensee's residents. On June 9, 2025, at 8:07 a.m., the surveyor observed ULP-C assist R3 with morning medication administration. ULP-C's employee record did not include a screening for active TB with either a two-step TST or blood test. On June 9, 2025, at 3:41 p.m., licensed assisted living director (LALD)-A stated she was unable to locate the documentation of ULP-C's two-step TST in ULP-C's employee record. The licensee's TB prevention and control policy dated December 9, 2022, indicated upon hire all staff are tested for tuberculosis with either a two-step Mantoux or an IGRA laboratory blood test. The results of the TB test will be recorded and kept in the employee's medical file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the	0 775		

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0 775	Continued From page 7 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 the potential to affect a large portion or all of the residents). Findings include: On June 11, 2025, from 10:30 a.m. to 1:30 p.m., the surveyor toured the facility with maintenance (M)-G. During the tour, the surveyor observed: FIRE ALARM PANEL: Facility provided the annual fire alarm report that showed no deficiencies, but during survey that panel was observed to have a warning light on. M-G, wasn't sure or aware of any issues. On June 18, 2025, at 9:22 am, M-G called me and advised that the fire panel is being replaced but didn't know when. CARBON MONOXIDE ALARM: Facility doesn't have carbon monoxide alarms outside of the bedrooms or in the mechanical rooms. Carbon monoxide alarms should be within 10' on the outside of the sleeping room or at the source of the fuel fired appliance. ESCUTCHEON: It was observed that several sprinkler heads throughout the facility were missing escutcheon covers. Escutcheon covers are required to cover the gap between the sprinkler and the ceiling or wall to prevent heat from escaping in other spaces which can delay sprinkler activation.	0 775		

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0 775	Continued From page 8 DOOR LOCKS: Both facility kitchens have doors leading out to a fenced in patio area. The doors have a slide bolt style lock on the upper area of the door. Doors can only have 2 separate locking mechanism, doors in the kitchen have 3. During a facility tour on June 11, 2025, at 12:30 p.m., M-G, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
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	0 810		

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0 810	Continued From page 9 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 the required content and provide the required training and drills. 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 June 11, 2025, from 10:30 a.m. to 1:30 p.m., the surveyor toured the facility with maintenance (M)-G., surveyor observed the posted evacuation plans lacked evacuation routes and had 2 different plans posted at each exit door. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions for egress in	0 810		

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0 810	Continued From page 10 a fire or similar emergency. Facility floor plan was also not part of the fire safety and evacuation plan (FSEP). June 11, 2025, from 10:30 a.m. to 1:30 p.m., with LALD-A; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Evacuation Plan", undated, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On June 11, 2025, at 12:30 p.m., LALD-A stated	0 810		

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0 810	Continued From page 11 they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated new hires were only doing fire training through a third-party website, no other training documentation was provided. On June 11, 2025, at 12:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD-A stated drills were being used to teach staff and review evacuation plan. On June 11, 2025, at 12:30 p.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30771	A. BUILDING: _____ B. WING _____	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PSC OF NEW ULM LLC	1304 BIRCHWOOD DRIVE NEW ULM, MN 56073

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0 900	Continued From page 12	0 900		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have the resident agree in writing any amendments to the contract for two of two residents (R2, R3) who had an amendment to	0 900		

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0 900	Continued From page 13 their contract. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee's Comprehensive Home Care license on December 19, 2015. R2's Assisted Living with Dementia Care Contract was signed on August 1, 2021. R3 R3 was admitted to the licensee's Comprehensive Home Care license on December 10, 2021. R3's Assisted Living with Dementia Care Contract was signed on December 10, 2021. On June 11, 2025, at 11:23 a.m., licensed assisted living director (LALD)-A stated the resident contract was revised in 2023. R3 and R4's record lacked the revised contract to include the licensee's health facility's identification number (HFID). In addition, LALD-A stated there were nine total residents with the older version of the contract. No further information was provided.	0 900		

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0 900	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for two of two employees (unlicensed personnel (ULP)-E, housekeeper (H)-F). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on June 11, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01290		

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01290	Continued From page 15 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired on February 2, 2022, and provided direct care services to the licensee's residents. On June 11, 2025, at 11:48 a.m., ULP-E stated she works independently as an unlicensed personnel full time. On June 11, 2025, at 12:26 p.m., the surveyor observed ULP-E administer R2's noon medications. H-F H-F was hired on August 17, 2018, and provided housekeeping services for the licensee. On June 11, 2025, at 11:45 a.m., H-F stated he works independently as a housekeeper three days a week. On June 11, 2025, at 12:50 p.m., the surveyor observed H-F vacuuming the licensee's public areas. On June 11, 2025, at 12:20 p.m., the surveyor reviewed the NETStudy 2.0 website and rosters with licensed assisted living director (LALD)-A. LALD-A stated ULP-E and H-F were listed on the NETStudy 2.0 roster with COVID 19-Expired	01290		

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01290	Continued From page 16 studies. LALD-A further stated the licensee had a hard time getting staff to go and have the background study updated. The licensee's Personnel Records policy revised June 1, 2023, indicated the personnel record for each employee would include documentation of a completed background study. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On June 11, 2025, the licensee took immediate action; however, the scope and level remains at I.	01290		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label and included the opened date on a time-sensitive drug for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01890		

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01890	Continued From page 17 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on December 19, 2015, with diagnoses that included diabetes. R2's Service Plan dated August 8, 2024, indicated R2 received services to include medication administration. R2's provider's order dated May 17, 2025, included an order for Systane Solution; instill 1 drop into both eyes three times daily and Humalog Kwikpen; inject 7 units subcutaneously at breakfast and lunch. On June 10, 2025, at 8:56 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with morning medication administration. Systane Solution was observed and verified missing an original prescription label and R2's opened Humalog Kwikpen lacked a date opened for a time sensitive drug. On June 10, 2025, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated R2's Systane Solution should have a pharmacy label on it, and the Humalog Kwikpen should have an opened date. The manufacturer's instructions for Humalog Kwikpen insulin dated 2024, directed to discard the pen 28 days after it had been opened. No further information provided.	01890		

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01890	Continued From page 18 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 must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; 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 interview and record review, the licensee failed to conduct mitigation for hazard vulnerability or safety risk assessment on or around the facility property. 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 the potential to affect a large portion or all residents). The findings include:	02040		

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02040	Continued From page 19 During record review on June 11, 2025, from 10:30 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-A. The licensee failed to provide mitigation for the hazards on the hazard vulnerability assessment (HVA). Facility did have a HVA completed with percentages assigned to each vulnerability, the assessment was missing mitigations to take when and if those hazards happened. On June 11, 2025, at 12:30 p.m. LALD-A stated they understood the requirements and would implement mitigations for hazards identified on HVA. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Prairie Senior Cottages of New Ulm
1304 Birchwood Drive
New Ulm, MN 56073
Brown County
Parcel:

Phone:

License Info

License: HFID 30771

Risk:
License:
Expires on:
CFPM: Romaine C Thormodson
CFPM #: FM98755; Exp: 9/13/2026

Inspection Info

Report Number: F1034251024
Inspection Type: Full - Single
Date: 6/9/2025 Time: 11:35:32 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Discussed employee illness reporting requirements. Employee Illness Log sent with report.

Inspection conducted in conjunction with HRD.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Mankato District Office inspection report number F1034251024 from 6/9/2025

Romaine C Thormodson

McKenna Mathews, RS
Public Health Sanitarian 2
507-344-2729
mckenna.mathews@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

Prairie Senior Cottages of New Ulm
New Ulm
County/Group: Brown County

Inspection Info

Report Number: F1034251024
Inspection Type: Full
Date: 6/9/2025
Time: 11:35:32 AM

Equipment Temperature: Product/Item/Unit: Upright Cooler**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Yogurt**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40.2 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Turkey**; Temperature Process:** Cooking
Location: Stove at 167 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Beets**; Temperature Process:** Cooking (plant foods)
Location: Stove at 170 Degrees F.
Comment:
Violation Issued?: No