Electronically Delivered

October 16, 2025

Licensee
Prairie Senior Cottages of New Richland
113 1st Street Southwest
New Richland, MN 56072

RE: Project Number(s) SL30606016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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
	30606	A. BUILDING: _____ B. WING _____	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SENIOR COTTAGES OF NEW RICHLA	113 1ST STREET SW NEW RICHLAND, MN 56072

(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: SL30606016-0 On September 15, 2025, through September17, 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 15 residents; 15 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted with the required content as indicated in Minnesota Administrative Rule 4659.0180. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect 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 the residents). The findings include: The licensee held an Assisted Living with Dementia Care license for a bed capacity of 18 residents. At the time of the survey, there were 15 residents; 15 receiving services under the Assisted Living Facility with Dementia Care license. During the entrance conference on September 15, 2025, at 1:13 p.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the staffing shift hours were as follows: Day shift: three unlicensed personnel (ULP)- 6:00 a.m. - 2:00 p.m. Evening shift: two ULP 2:00 p.m. - 10:00 p.m., one ULP 4:00 p.m. - 8:00 p.m. Night shift: Two ULP 10:00 p.m. - 6:00 a.m. On September 8, 2025, at 11:45 a.m., the surveyor observed the daily staff schedule posted on a board in the dining room near the front door. The posting included the names of three ULP and their assignments. The schedule did not indicate the specific times of each shift. On September 15, 2025, at 1:57 p.m., CNS-B stated the posted schedule did not include the times of each shift.	0 470		

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0 470	Continued From page 3 Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective January 13, 2025, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily staffing schedule must be posted, after reacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated reviewed March 6, 2025, noted the 24-hour daily staffing schedule will include: -Direct-care staff work schedules for each direct-care staff member -Indication of all work shifts, including days and hours worked -Identify direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.	0 480		

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0 480	Continued From page 4 (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant	0 480		

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0 480	Continued From page 5 lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 510	Continued From page 6	0 510		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and 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 effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of two employees (unlicensed personnel (ULP-C, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	0 510		

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0 510	Continued From page 7 On September 16, 2025, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-C don a pair of clean gloves, obtain R1's blood sugar and administer the resident's medications including an eye drop and insulin injection. Following the completion of tasks, ULP-C removed gloves and did not perform hand hygiene. On September 16, 2025, at 7:41 a.m., the surveyor observed ULP-C to administer R8's medications wearing gloves. ULP-C did not perform hand hygiene before or after donning and doffing the gloves. On September 16, 2025, at 8:40 a.m. without sanitizing or washing hands, ULP-C donned a pair of clean gloves and prepared R6's medications in the medication room. Wearing the same gloves, ULP-C then entered R6's room accompanied by ULP-F who also donned a pair of clean gloves without washing or sanitizing hands. Both ULPs assisted R6 to a sitting position on the side of his bed and sat on R6's bed while trying to wake him by rubbing his back and arms. ULP-C and ULP-F were unsuccessful in waking R6 for his medications, and they assisted to lay the resident back down in his bed. ULP-F removed her gloves prior to exiting the room; however, ULP-F did not wash or sanitize her hands after removing the gloves. ULP-C proceeded to walk out of the room still wearing the same gloves, opened the locked medication coded door, opened the drawer of medication cart, obtained an envelope and dumped the medications that she was unable to administer to R6 into it and labeled it. ULP-C then removed her gloves. She did not sanitize or wash her	0 510		

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0 510	Continued From page 8 hands after removing the gloves. On September 16, 2025, at 11:50 a.m., ULP-C brought R3 into the medication room. Without sanitizing or washing her hands, ULP-C applied gloves and completed R3's blood sugar check. While wearing the same gloves, ULP-C opened the medication room door, went into the kitchen, removed the gloves, applied a pair of clean gloves, and began serving food. ULP-C did not sanitize or wash her hands before or after removing the gloves. On September 16, 2025, at 1:46 p.m., ULP-C stated hands are to be washed or sanitized before and after glove use. ULP-C further stated she was taught to wear gloves for all medication related tasks and identified there was hand sanitizer on the medication cart. On September 17, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-B stated staff should wash hands or sanitize before and after glove use. CNS-B further indicated all staff were instructed on this process. The licensee's Hand Hygiene policy dated reviewed March 6, 2025, indicated: Handwashing is the single most effective way of controlling the spread of infection. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client d. after removing gloves or gowns The licensee's Procedure for using Gloves policy dated reviewed March 6, 2025, indicated: 1. Wash hands	0 510		

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0 510	Continued From page 9 2. Apply gloves to both hands 3. Complete task. If gloves become torn or heavily soiled and additional tasks must be performed, then change the gloves (washing hands before putting on new gloves before starting the next task). The licensee's Standard (Universal) Precautions for Infection Control policy dated reviewed March 6, 2025, noted standard precautions are devised to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. The policy included: Hand washing 1. Hand washing is crucial. Staff will wash hands: - immediately after gloves or gown are removed as necessary, between tasks and procedures on the same client to prevent cross-contamination of different body sites, and between all patient contacts. Gloves 2. Remove gloves promptly after use, and before touching non-contaminated items, environmental surfaces, self, or other clients. Wash hands after removing gloves. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	0 510		
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:	0 775		

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0 775	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on September 16, 2025, from 12:28 p.m. through 1:02 p.m., with maintenance (M)-D, the surveyor observed exterior doors with exits signs above them that were equipped with magnetic locks that required a fob to unlock. The surveyor did not observe a button or switch that would deactivate the locks. M-D stated they were not aware of a switch in the building that would deactivate the locks. The locks were not capable of being deactivated by a signal or switch located in an approved location as required in State Fire Code in Minnesota Rules, chapter 7511. During same tour the surveyor observed the front exit door had a vestibule. The door from the facility into the vestibule and the door out of the vestibule to the exterior were both equipped with magnetic locks that required a fob to unlock. State Fire Code in Minnesota Rules, chapter 7511 states that building occupants shall not be	0 775		

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(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
0 775	Continued From page 11 required to pass through more than one controlled egress door before exiting the building. During same tour the surveyor observed the rear exit door by the sunroom led into a fenced courtyard that had a locked gate. M-D stated the gate lock would not unlock upon activation of the building fire alarm system and was not capable of being unlocked by a signal or switch. State Fire Code in Minnesota Rules, chapter 7511 requires all evacuation routes be unobstructed to the public way. M-D verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	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	0 810		

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	30606	A. BUILDING: _____ B. WING _____	09/17/2025

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0 810	Continued From page 12 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at 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 interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 13 On September 16, 2025, at 1:10 p.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensees FSEP titled, Document No: ES - 9.0, dated June 29, 2023, failed to include the following: The FSEP did not include an evacuation map with a floor plan accurate to the building layout that showed the location and number of resident sleeping rooms. The FSEP included employee procedures for evacuation 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 instructions to evacuate residents beyond the closest set of corridor fire/smoke barrier doors and into an adjacent smoke compartment. This facility did not have corridor fire/smoke barrier doors or separate smoke compartments. The FSEP included resident evacuation procedures according to their physical condition but failed to identify which residents required assistance by assessing the individualized unique needs of residents. 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	0 810		

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0 810	Continued From page 14 follow in case of a fire or similar emergency. During an interview on September 16, 2025, at 1:55 p.m., LALD-A stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must	01060		

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01060	Continued From page 15 be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one hospitalized resident (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 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: R2 began receiving assisted living services on May 16, 2025. R2's Service Plan dated effective July 2, 2025, indicated R2 received assistance with bathing,	01060		

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01060	Continued From page 16 AM/PM cares, support stockings, toileting, CPAP (continuous positive airway pressure) (machine to keep the airways open while you sleep), transfers/ambulation/mobility and medication administration. R2's Progress Notes dated July 4, 2025, at 9:33 a.m., indicated R2 had a fall in the night and was unable to bear any weight on left leg. R2's family requested R2 be taken to the emergency department via ambulance. Progress Notes dated July 4, 2025, at 3:28 p.m., identified R2 had been admitted to the hospital. Progress Notes dated July 7, 2025, at 4:26 p.m., identified R2 returned to the facility following the hospitalization. R2's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On September 16, 2025, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated no written notice was provided to R2, or any resident that	01060		

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01060	Continued From page 17 had been emergently relocated less than four days. CNS-B further stated he thought the notice only needed to be given out to the resident and ombudsman if the resident was relocated greater than four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
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 observation, interview, and record review, the licensee failed to ensure the prescription label matched the order for one of five residents (R4) observed during medication administration. 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).	01890		

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01890	Continued From page 18 The findings include: R4's diagnoses included Alzheimer's disease, restlessness, and agitation. R4's Service Plan (Private) - Addendum to Contract effective July 2, 2025, included medication administration. R4's prescriber orders dated September 11, 2025, included: - Seroquel (antipsychotic medication) 25 milligrams (mg) four times daily and 37.5 mg at 2:00 p.m. for agitation. R4's medication administration record (MAR) dated September 2025, included the medication as ordered above. On September 17, 2025, at 9:05 a.m., the surveyor observed unlicensed personnel (ULP)-E administer quetiapine (generic name for Seroquel) to R4. The quetiapine had a label that directed to administer 50 mg take 1/2 tablet five times daily. When interviewed at this time, ULP-E stated the label for R4's quetiapine did not match the MAR or indicate the order had changed, but said she would follow the MAR instead of the label. On September 17, 2025, at 10:38 a.m., clinical nurse supervisor (CNS)-B stated the quetiapine order had just changed. CNS-B indicated he had notified staff but should have put a "directions changed refer to chart" sticker on the medication label itself. CNS-B further stated the prescription labels should match the current prescriber orders and MAR.	01890		

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01890	Continued From page 19 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as prescribed, or to document the reason they were not provided, 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 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:	01960		

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01960	Continued From page 20 R2's diagnoses included mild cognitive impairment, high blood pressure, and atrial fibrillation (irregular heart rhythm). . R2's Service Plan (Private)- Addendum to Contract dated July 2, 2025, indicated R2 received assistance with support stockings (compression socks) twice daily. R2's physician orders dated May 16, 2025, included an order for compression stockings on in AM and off in PM. On both September 16, 2025, at 11:04 a.m., and September 17, 2025, at 8:22 a.m., the surveyor observed R2 sitting at the dining room table wearing socks and shoes. R2 was not wearing compression stockings. On September 16, 2025, at 2:10 p.m., unlicensed personnel (ULP)-C stated R2 did not wear compression stockings. On September 17, 2025, at 8:30 a.m., ULP-E stated R2 was supposed to wear compression stockings but didn't have any to put on. ULP-E indicated the compression stockings had been missing for more than a month. R2's compression stocking instructions for staff AM and PM shift included: application or removal of support stockings. Notify registered nurse if toes are cold or bluish, leg pain or cramps, or skin irritation. R2's recorded support stockings service history dated August 17, 2025, through September 17, 2025, included staff initials that compression	01960		

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01960	Continued From page 21 stockings had been applied or removed on the following dates: August 17, 2025, both AM and PM shift; August 18, 2025, both AM and PM shift; August 19, 2025, PM shift; August 20, 2025, both AM and PM shift; August 21, 2025, AM shift; August 22, 2025, AM shift; August 23, 2025, PM shift; August 24, 2025, PM shift August 25, 2025, AM shift; August 26, 2025, AM shift; August 27, 2025, both AM and PM shift; August 28, 2025, both AM and PM shift; August 29, 2025, both AM and PM shift; August 30, 2025, PM shift; August 31, 2025, both AM and PM shift; September 1, 2025, PM shift; September 2, 2025, both AM and PM shift; September 3, 2025 both AM and PM shift; September 4, 2025, PM shift September 5, 2025, both AM and PM shift; September 6, 2025, PM shift; September 7, 2025 PM shift; September 8, 2025, AM shift; September 9, 2025, both AM and PM shift; September 10, 2025, both AM and PM shift; September 11, 2025, both AM and PM shift; September 12, 2025, both AM and PM shift; September 13, 2025, both AM and PM shift; September 14, 2025, both AM and PM shift; September 15, 2025, both AM and PM shift; September 16, 2025, both AM and PM shift; On September 17, 2025, at 8:55 a.m., clinical nurse supervisor (CNS)-B stated he was not aware staff were not applying the compression stockings to R2 and indicated staff should not document the task as completed if they are not	01960		

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01960	Continued From page 22 applying the stockings. CNS-B further indicated he would need to order R2 another pair of compression stockings. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated reviewed March 6, 2025, included staff would document each task immediately after that task has been performed. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel dated reviewed March 6, 2025, included medications, treatment and therapy always need to be administered according to the "6 Rights" a. Right person b. Right medication, treatment or therapy c. Right time d. Right route e. Right dose f. Right chart/record to document that the medication, treatment and therapy was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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
113 SOUTH ASH STREET
New Richland, MN 56072
Waseca
Parcel:

Phone:

License Info

License: HFID 30606

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1034251140
Inspection Type: Full - Single
Date: 9/16/2025 Time: 11:15:13 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: Melissa's CFPM has expired. Take a food safety course and register with the state again.
Comply By: 11/16/2025 Originally Issued On: 9/16/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: Need test strips for quat sanitizer. Test solution at least 3 times weekly to ensure it is coming out at the right concentration.
Comply By: 9/26/2025 Originally Issued On: 9/16/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C3 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.
COMMENT: Sanitizer spray bottle was too weak with a concentration of 0 ppm. Concentration should be 200-400 ppm for quat-based sanitizers. Dispenser also tested at wrong concentration, so establishment will use another sanitizer that is approved for food-contact surfaces, likely clorox bleach.
Comply By: 9/16/2025 Originally Issued On: 9/16/2025

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: Need a handwashing sign at kitchen handwashing sink.
Comply By: 9/23/2025 Originally Issued On: 9/16/2025

! **New Order: 7-200 Toxic Supplies and Applications**
7-204.11 *Priority Level: Priority 1 CFP#: 28*
MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.
COMMENT: Quat sanitizer dispenser tested at >500 ppm. Ensure quat solution is coming out at the proper concentration (200-400 ppm). Call servicing company to fix. Use a different sanitizer that is approved for food-contact surfaces until it comes out at correct concentration.
Comply By: 9/16/2025 Originally Issued On: 9/16/2025

Food & Beverage General Comment

Establishment makes food for day-of service. Establishment does not serve any leftovers to residents. All leftovers are given to staff.

Discussed importance of cleaning both the hood filters and the duct work (inside) of the hood. Establishment will have a company come and clean the duct work, as it has not been cleaned since they took over as owners.

Employee illness fact sheet and log provided with report.

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 F1034251140 from 9/16/2025

Melissa

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