Electronically Delivered

December 9, 2025

Licensee
Prairie Senior Cottages of Albert Lea
1602 Fountain Street
Albert Lea, MN 56007

RE: Project Number(s) SL29690016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 20, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

**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

CLN

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 29690 | A. BUILDING: _____ B. WING _____ | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRAIRIE SENIOR COTTAGES OF AL | 1602 FOUNTAIN STREET ALBERT LEA, MN 56007 |

| (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 |
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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL29690016-0<br><br>On November 18, 2025, through November 20, 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 21 residents; 21 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br><br>(11) develop and implement a staffing plan for | 0 470 | | |

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| 0 470 | Continued From page 1<br><br>determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(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<br>(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;<br>(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:<br>(i) awake;<br>(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;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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) | 0 470 | | |

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| 0 470 | Continued From page 2<br><br>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).<br><br>The findings include:<br><br>The licensee held an Assisted Living with Dementia Care license for a bed capacity of 26 residents. At the time of the survey, there were 21 residents; 21 receiving services under the Assisted Living Facility with Dementia Care license.<br><br>During the entrance conference on November 18, 2025, at 11:26 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the staffing shift hours were as follows:<br>Day shift: two unlicensed personnel (ULP) 6:00 a.m. - 2:00 p.m., and two ULP 7:00 a.m. - 3:00 p.m.<br>Evening shift: two ULP 2:00 p.m. - 10:00 p.m., two ULP 3:00 p.m. - 9:00 p.m., and one ULP 4:00 p.m. - 8:00 p.m.<br>Night shift: one ULP 10:00 p.m. - 6:00 a.m., and one ULP 7:00 p.m. - 7:00 a.m.<br><br>On November 18, 2025, at 12:26 p.m., the surveyor observed the daily staff schedule posted on a whiteboard in both dining rooms with licensed assisted living director (LALD)-A. The posting included the date with titles AM, PM and NOC (night), and names of the ULPs on their respective work location. The schedule did not indicate the specific times of each shift. At this time, LALD-A stated she was not aware the times needed to be identified on the posting, further indicating she thought AM, PM, and NOC was easier for people to understand. | 0 470 | | |

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| 0 470 | Continued From page 3<br><br>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:<br>(1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and<br>(2) identify the direct-care staff member's resident assignments or work location.<br>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.<br><br>The licensee's Direct-Care Staffing Plan dated reviewed September 3, 2025, noted the schedule will include how many staff, what type of staff, when and where staff are assigned.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 470 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current 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 | 0 660 | | |

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| 0 660 | Continued From page 4<br><br>covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a current two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of two employees (unlicensed personnel (ULP)-D).<br><br>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).<br><br>The findings include:<br><br>The licensee's Facility TB Risk Assessment dated June 3, 2025, did not identify the risk level of the licensee.<br><br>ULP-D had a hire date of May 17, 2024.<br><br>ULP-D's record included a TB symptom screen | 0 660 | | |

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| 0 660 | Continued From page 5<br><br>dated May 31, 2024, and a negative two-step TST dated December 18, 2023. The record lacked evidence of TB testing upon hire or within 90 days prior to hire.<br><br>On November 20, 2025, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated ULP-D's record did not include evidence TB testing had been completed upon hire or within 90 days of hire. CNS-B stated she thought employees could begin working if they had a previous TB testing within 12 months of hire.<br><br>The licensee's TB Prevention and Control policy dated reviewed December 9, 2022, noted if a staff member presents a two-step Mantoux with negative results or a negative IGRA (serum blood test) within 90-days of hire, this will be used for proof of negative result and the staff member does not need further testing.<br><br>"Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the health care worker (HCW) starts working with patients. Baseline TB screening should be documented in the employee's record."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |

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| 0 810 | Continued From page 6 | 0 810 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record | 0 810 | | |

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| 0 810 | Continued From page 7<br><br>review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 19, 2025, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 0 810 | | |
| 01890 SS=E | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee | 01890 | | |

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| 01890 | Continued From page 8<br><br>failed to ensure medications were maintained bearing the original prescription label with legible information for two of two residents (R1, R4) with insulin.<br><br>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).<br><br>The findings include:<br><br>R1<br>R1's diagnoses included diabetes.<br><br>R1's Service Plan (Waiver) - Addendum to Contract dated effective November 10, 2025, included medication administration.<br><br>R1's prescriber orders dated June 30, 2025, included an order for Lantus (long-acting insulin) SoloStar inject 9 units subcutaneously daily and Novolog (rapid-acting insulin) inject 5 units subcutaneously three times daily with meals.<br><br>R1's medication administration record (MAR) dated November 1, 2025, through November 18, 2025, included the above orders.<br><br>On November 19, 2025, at 9:47 a.m., the surveyor observed unlicensed personnel (ULP)-D administer insulin to R1. R1's medications were stored in a bin within a locked medication cupboard labeled with R1's name. ULP-D | 01890 | | |

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| 01890 | Continued From page 9<br><br>removed R1's NovoLog pen and Lantus SoloStar pen from the plastic bin, prepared following directions on the MAR and administered to R1. Though both insulin pens included R1's name and were dated when opened, they lacked the original prescription label with information regarding the directions for use, medication name, medication dosage, and the pharmacy in which it had been dispensed. When interviewed at this time, ULP-D stated R1's insulin pens did not include a label with directions but would follow the directions on the computer for administration.<br><br>R4<br>R4's diagnoses included mild cognitive impairment and diabetes.<br><br>R4's Service Plan (Waiver) - Addendum to Contract dated effective February 24, 2023, included medication administration.<br><br>On November 19, 2025, at 10:11 a.m., the surveyor observed R4's insulin pens with ULP-C. R4's insulin pens were stored in a bin within a locked medication cupboard labeled with R4's name. Though R4's Basaglar (long-acting insulin) KwikPen and Admelog (rapid-acting insulin) SoloStar pen included R4's name and were dated when opened, they lacked the original prescription label with information regarding the directions for use, medication name, medication dosage, and the pharmacy in which it had been dispensed.<br><br>On November 19, 2025, at 10:14 a.m., clinical nurse supervisor (CNS)-B stated all medication should have original prescription labels. CNS-B further stated staff need to keep the insulin in the plastic baggie they come with, further indicating staff had thrown the baggie away bearing the | 01890 | | |

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|---|---|---|---|---|
| 01890 | Continued From page 10<br>original label.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02040 SS=C | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements:<br>(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<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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 the potential to | 02040 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 29690 | A. BUILDING: _____ B. WING _____ | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PRAIRIE SENIOR COTTAGES OF AL | 1602 FOUNTAIN STREET ALBERT LEA, MN 56007 |

| (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 |
|---|---|---|---|---|
| 02040 | Continued From page 11<br>affect a large portion or all the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated 11-19-25, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 02040 | | |
| 02320 SS=D | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed by one of two employees (unlicensed personnel (ULP)-D) observed during medication administration.<br><br>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 | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| PRAIRIE SENIOR COTTAGES OF AL | 1602 FOUNTAIN STREET ALBERT LEA, MN 56007 |

| (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 |
|---|---|---|---|---|
| 02320 | Continued From page 12<br>a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's diagnoses included osteoarthritis (degenerative joint disease).<br><br>R1's Service Plan (Waiver) - Addendum to Contract dated November 10, 2025, included medication administration.<br><br>R1's prescriber orders dated October 1, 2025, included an order for diclofenac (topical pain relief) 1% gel. Apply 4 grams topically to right knee twice daily, and twice daily as needed for pain.<br><br>R1's medication administration record (MAR) dated November 1, 2025, through November 18, 2025, included diclofenac gel 1% gel apply 4 grams topically twice daily to right knee.<br><br>On November 19, 2025, at 9:47 a.m., the surveyor observed ULP-D prepare and administer medications to R1. ULP-D reviewed R1's MAR, sanitized hands, donned clean gloves, and placed a dime sized amount of R1's diclofenac 1% gel to her gloved hand. ULP-D applied the dime sized amount of gel to R1's right knee. ULP-D did not measure the amount of diclofenac gel applied. Following the application of the gel, ULP-D removed gloves, sanitized hands, and documented the diclofenac 1% gel administration. When interviewed at this time, ULP-D stated she was not aware how to measure 4 grams utilizing the plastic dosing card that comes with the medication.<br><br>On November 19, 2025, at 10:56 a.m., clinical | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PRAIRIE SENIOR COTTAGES OF AL | 1602 FOUNTAIN STREET ALBERT LEA, MN 56007 |

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|---|---|---|---|---|
| 02320 | Continued From page 13<br><br>nurse supervisor (CNS)-B stated staff were taught and instructed to use the plastic dosing card that comes with the medication for an accurate measurement of the medication.<br><br>The Voltaren (brand name for diclofenac) instructions for use revised May 2016, identified to use the dosing card to correctly measure each dose. Place the dosing card on a flat surface so that you can read the print. Squeeze the gel onto the dosing card evenly, up to the 4-gram line (a 4.5-inch length of gel). Make sure that the gel covers the 4-gram area of the doing card. After using the dosing card, hold end with fingertips, rinse and dry. Store the dosing card until next use.<br><br>The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated reviewed March 6, 2025, noted medications always need to be administered according to the "6 Rights":<br>- Right person<br>- Right medication<br>- Right time<br>- Right route (by mouth, eye drop, to the skin)<br>- Right dose (how many milligrams, drops)<br>- Right chart/record to document that the medication was taken.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

# Food & Beverage Inspection Report



## Establishment Info

PRAIRIE COTTAGES OF ALBERT LEA
1602 FOUNTAIN STREET
Albert Lea, MN 56007
Freeborn County
Parcel:

Phone:
deyaniram@pscminn.com

## License Info

License: HFID 29690
Deyanira Mondragon
Risk:
License:
Expires on:
CFPM: Deyanira Mondragon
CFPM #: 121073; Exp: 12/27/2026

## Inspection Info

Report Number: F1038251129
Inspection Type: Full - Single
Date: 11/18/2025 Time: 7:31:07 AM
Duration: 45 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.

**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 Rochester District Office inspection report number F1038251129 from 11/18/2025**

Deyanira Mondragon

Rob Davis,
Public Health Sanitarian 2
rob.davis@state.mn.us