Electronically Delivered

February 20, 2026

Licensee
Prairie Winds Senior And Assisted Living
910 3rd Avenue
Madison, MN 56256

RE: Project Number(s) SL39233016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 2026, 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

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39233	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE WINDS SENIOR AND ASSISTED LIVIN	910 3RD AVENUE MADISON, MN 56256

(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: SL39233016-0 On January 20, 2026, through January 22, 2026, 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 17 residents; 14 receiving services under the Assisted Living Facility 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.	
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies	0 500		

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0 500	Continued From page 1 and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and	0 500		

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0 500	Continued From page 2 (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. 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 January 20, 2026, at 11:43 a.m., the licensee's policies and procedures were requested. The provided policies lacked development of: - ensuring that nurses and licensed health professionals had current and valid licenses to practice. The licensee's Application for Assisted Living License signed by authorized agent (AA)-F on July 8, 2025, included a check mark on page six indicating AA-F attested to having all the required policies and procedures. On January 21, 2026, at 10:06 a.m., human	0 500		

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0 500	Continued From page 3 resources director (HRD)-G stated HRD-G verified all licensed staff possessed a valid license for their respective position and maintained that license through the duration of their employment with [licensee] however, a written policy to address this practice was not created. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	0 680		

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0 680	Continued From page 4 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility. 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: During the entrance conference on January 20, 2026, at 10:25 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP dated March 2025, lacked the following content and/or policies and procedures to address: - a missing resident plan that was reviewed quarterly; - identified at-risk population needs; and - a communication plan which addresses the method for sharing information from the	0 680		

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0 680	Continued From page 5 emergency plan with residents and their families/representatives. On January 22, 2026, at 9:09 a.m., LALD/CNS-A stated resident evacuation needs are addressed in each assessment however they are not included in the EPP. LALD/CNS-A further stated sharing information from the EPP with family was the responsibility of the charge nurse however that is not identified in the EPP. On January 22, 2026, at 9:45 a.m., LALD/CNS-A stated quality and safety risk manager (QSRM)-H informed LALD/CNS-A the elopement policy was reviewed twice in 2025. LALD/CNS-A further stated the quarterly review requirement for the elopement policy was missed. The licensee's Emergency Operations Plan policy revised March 2025, indicated necessary training was provided for the licensee's EPP for all the above-mentioned items except the policy did not address at-risk population needs and a communication plan to address how information from the EPP was to be shared with residents and their families/representatives. The licensee's Elopement policy revised September of 2025, indicated how the licensee's staff would respond to a missing resident scenario however, it did not address the requirement of quarterly review of the policy. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, LALD and CNS must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules	0 680		

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0 680	Continued From page 6 Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=D	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, 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. 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	0 775		

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0 775	Continued From page 7 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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 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	0 810		

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0 810	Continued From page 8 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 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. 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 9 (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 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	01060		

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01060	Continued From page 10 (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 written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one 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: During the entrance conference on January 20, 2025, at 10:25 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. R2 was admitted to the facility on February 14, 2025, and began receiving assisted living	01060		

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01060	Continued From page 11 services. R2's diagnoses included hypertension (elevated blood pressure), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing difficulties), and history of nontraumatic intracerebral hemorrhage (stroke subtype from spontaneous bleeding directly into the brain). R2's Service Plan Report signed on September 12, 2025, indicated R2's services included stand-by assistance with transfers and ambulation, dressing, bathing, toileting, medication management, laundry, housekeeping, and safety checks. R2's Progress Notes *New* [sic] dated November 1, 2025, through January 20, 2026, included the following entries: -December 23, 2025, at 11:50 a.m., "RN (registered nurse) called to resident room for stroke like symptoms, obvious facial drooping and slurred speech noted. Assisted with two staff and gaitbelt to wheelchair. Resident taken down in wheelchair by aide staff and daughter walking with. MAR (medication administration record) printed off and sent with. Hospital called and updated." -December 23, 2025, at 2:51 p.m., "[R2] is being transferred by air to [hospital]." -January 6, 2026, at 1:35 p.m., "[R2] returned from [hospital] via wheelchair, escorted by daughter [name] at 12:50 PM." 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	01060		

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01060	Continued From page 12 and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD); - 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 - 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. In addition, R2's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On January 22, 2026, at 11:11 a.m., LALD/CNS-A stated a progress note was entered in a resident's medical record and facility census updated when a resident went to the emergency room or hospital however, [licensee] did not have a form with the required content nor was the OOLTC updated. LALD/CNS-A further stated emergency relocation notice requirements were missing for all residents and would be fixed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39233	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE WINDS SENIOR AND ASSISTED LIVIN	910 3RD AVENUE MADISON, MN 56256

(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
01290	Continued From page 13 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 interview and record review, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) 39233 for five of 17 employees (unlicensed personnel (ULP)-I, ULP-J, ULP-K, ULP-L, and ULP-M). 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: During the entrance conference on January 20, 2026, at 10:54 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39233	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE WINDS SENIOR AND ASSISTED LIVIN	910 3RD AVENUE MADISON, MN 56256

(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
01290	Continued From page 14 stated the licensee was aware of the required contents of the employee record. On January 20, 2026, at 12:31 p.m., LALD/CNS-A provided the licensee's NETStudy 2.0 (background study website) roster screenshots for HFID 39233 via email. ULP-I ULP-I was hired on July 25, 2022, to provide direct care services to residents at the assisted living facility. ULP-I's employee record contained a cleared background study for HFID 328, dated July 14, 2022. ULP-I's employee record lacked a cleared background study for the licensee's HFID 39233. ULP-J ULP-J was hired on September 16, 2024, to provide direct care services to residents at the assisted living facility. ULP-J's employee record contained a cleared background study for HFID 329, dated September 12, 2024. ULP-J's employee record lacked a cleared background study for the licensee's HFID 39233. ULP-K ULP-K was hired on January 3, 2023, to provide direct care services to residents at the assisted living facility. ULP-K's employee record contained a cleared background study for HFID 328, dated December 19, 2022. ULP-K's employee record lacked a cleared background study for the licensee's HFID 39233.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39233	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE WINDS SENIOR AND ASSISTED LIVIN	910 3RD AVENUE MADISON, MN 56256

(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
01290	Continued From page 15 ULP-L ULP-L was hired on July 28, 2023, to provide direct care services to residents at the assisted living facility. ULP-L's employee record contained a cleared background study for HFID 329, dated July 19, 2023. ULP-L's employee record lacked a cleared background study for the licensee's HFID 39233. ULP-M ULP-M was hired on August 14, 2024, to provide direct care services to residents at the assisted living facility. ULP-M's employee record contained a cleared background study for HFID 329, dated August 6, 2003. ULP-M's employee record lacked a cleared background study for the licensee's HFID 39233. On January 20, 2026, at 1:30 p.m., LALD/CNS-A stated the above-mentioned employees were originally hired by another division of the parent company and background studies were likely completed under a different HFID. On January 21, 2026, at 10:06 a.m., human resources director (HRD)-G stated HRD-G was not aware background studies needed to be cross-affiliated for employees who were employed by more than one entity within the parent company. The licensee's Reference and Background Checks policy revised August 2010, indicated cleared background studies were completed prior to working for [licensee] for all employees who had direct resident contact. No further information was provided.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39233	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 16 TIME PERIOD FOR CORRECTION: Two (2) days	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 observation, interview, and record review, the licensee failed to monitor for expired medications in one of three resident rooms (R2). This practice resulted in a level two violation (a violation that did not harm a client'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: During the entrance conference on January 20, 2026, at 10:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility. R2 was admitted to the facility on February 14,	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39233	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE WINDS SENIOR AND ASSISTED LIVIN	910 3RD AVENUE MADISON, MN 56256

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01890	Continued From page 17 2025, and began receiving assisted living services. R2's diagnoses included hypertension (elevated blood pressure), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing difficulties), and history of nontraumatic intracerebral hemorrhage (stroke subtype from spontaneous bleeding directly into the brain). R2's Service Plan Report signed on September 12, 2025, indicated R2's services included stand-by assistance with transfers and ambulation, dressing, bathing, toileting, medication management, laundry, housekeeping, and safety checks. On January 21, 2026, at 8:06 a.m., the surveyor observed R2's medication supply with unlicensed personnel (ULP)-D and observed the following expired medications: - ciprofloxacin 0.3% ophthalmic drops, partial bottle, expired November 2025; and - carbamide peroxide 6.5% otic drops, partial bottle, expired September 2025. On January 21, 2026, at 8:08 a.m., ULP-D stated resident's medication supplies were audited by nursing for expiration dates and labels however, staff were also trained to check medication expiration dates prior to administration to prevent medication errors. On January 21, 2026, at 8:15 a.m., LALD/CNS-A stated LALD/CNS-A audited resident medication supplies when medication cycle fills were delivered and prior to medication set-ups being performed. LALD/CNS-A further stated the expired medications were missed during audit.	01890		

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01890	Continued From page 18 The licensee's Disposition or Disposal of Medication policy revised May 2022, indicated unused medication stored in the resident's private living space was considered household waste and would be destroyed and documented by the licensee. The policy did not address expired medication destruction and documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 19 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R3) who had treatments or therapies managed by the licensee. 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: R3 was admitted to the licensee and began receiving assisted living services on November 14, 2022. R3's diagnoses included atrial fibrillation (rapid and irregular heart rhythm), diabetes, hypertension (elevated blood pressure), and congestive heart failure (chronic heart condition causing fluid retention).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 20 R3's prescriber orders dated October 3, 2025, included an order to have compression stockings applied in the morning and removed in the evening. R3's Standard Level of Care and Service Plan dated January 5, 2026, indicated R3 received assistance with applying compression stockings daily. R3's Documentation Survey Report v2 (sic) dated January 1, 2026, through January 31, 2026, indicated R3 received assistance with application of compression stockings on January 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20. On January 21, 2026, at 11:30 a.m., the surveyor observed R3 being served lunch by licensee staff and observed R3's compression stockings to be on. R3's record lacked evidence of an individualized treatment or therapy management plan which included the following: - procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services. On January 22, 2026, at 12:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R3's treatment administration lacked specific criteria for when to notify a RN due to LALD/CNS-A being unaware of the requirement to include that information. The licensee's Initial and On-Going Nursing Assessment of Residents policy revised October 2024, indicated a registered nurse completed an	01940		

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	39233	A. BUILDING: _____ B. WING _____	01/22/2026

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01940	Continued From page 21 assessment which included current treatments the resident requires, including the type, frequency and level of assistance needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards with regards to safely storing oxygen for one of one residents (R3) 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:	02310		

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02310	Continued From page 22 During the entrance conference on January 20, 2026, at 10:53 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided oxygen management to residents at the facility. R3 was admitted to the licensee and began receiving assisted living services on November 14, 2022. R3's diagnoses included atrial fibrillation (rapid and irregular heart rhythm), diabetes, hypertension (elevated blood pressure), and congestive heart failure (chronic heart condition causing fluid retention). R3's Documentation Survey Report v2 (sic) dated January 1, 2026, through January 31, 2026, indicated R3 received a daily safety/wellness check on the following dates: January 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16,17, 18, 19, and 20. On January 21, 2026, at 11:42 a.m., the surveyor accompanied by R3, observed oxygen storage within R3's room and observed one large oxygen concentrator, one portable oxygen conserver, and two portable oxygen tanks, one of which was not in an appropriate storage rack and was standing upright on the floor. On January 22, 2026, at 11:13 a.m., LALD/CNS-A stated staff were trained to assure oxygen tanks are stored upright and in an appropriate holder during safety checks. LALD/CNS-A further stated LALD/CNS-A was unaware R3 had inappropriately stored oxygen and staff re-education was needed due to inappropriate oxygen storage being missed.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 23 The licensee's Oxygen Services policy revised November 2025, indicated oxygen canisters stored outside of the designated oxygen storage room were stored in an oxygen cart. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

PRAIRIE WINDS SENIOR AND ASSIS
910 3rd Avenue
Madison, MN 56256
Lac Qui Parle
Parcel:

Phone:

License Info

License: HFID 39233

Risk:
License:
Expires on:
CFPM: Tammy Jo Willis
CFPM #: 89181; Exp: 5/21/2026

Inspection Info

Report Number: F7935261006
Inspection Type: Full - Single
Date: 1/22/2026 Time: 10:29:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

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 Fergus Falls District Office inspection report number F7935261006 from 1/22/2026

Rebecca Tonneson

Establishment Representative

Rebecca Tonneson, RS
Public Health Sanitarian Supervisor
218-332-5142
rebecca.tonneson@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

PRAIRIE WINDS SENIOR AND ASSIS
Madison
County/Group: Lac Qui Parle

Inspection Info

Report Number: F7935261006
Inspection Type: Full
Date: 1/22/2026
Time: 10:29:15 AM

Equipment Temperature: Product/Item/Unit: Fridge**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

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

Fergus Falls District Office
Minnesota Department of Health
2312 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

PRAIRIE WINDS SENIOR AND ASSIS
Madison
County/Group: Lac Qui Parle

Inspection Info

Report Number: F7935261006
Inspection Type: Full
Date: 1/22/2026
Time: 10:29:15 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL39233016-0	**Date:** 1/20/2026
Facility Name: Prairie Winds	
Facility Address: 910 3rd Avenue, Madison, MN 56256	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control devices shall not be modified. [Minn. Stat. 144G.45 subd. 2; MSFC 705.2]

   Comments: The fusible link on the sliding door at the base of the trash chute was broken. The door was wedged open and did not close properly.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD/CNS-A stated resident needs for evacuation are kept electronically in a program called Point Click Care. LALD/CNS-A stated resident needs are also in the resident service plans that are stored in the nurse's office. There was no direction in FSEP for how staff can access these resident needs.

2. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: LALD/CNS-A stated staff participate in fire drills and are provided training with third party providers Relias and Educare. LALD/CNS-A stated they did not have documentation of training provided to staff on the facility's FSEP.

3. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: LALD/CNS-A stated residents participate in fire drills. LALD/CNS-A stated they did not have documentation of FSEP training offered to the residents.