



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 6, 2025

Licensee
Prairie Cottages Of Owatonna
150 24th Street Northeast
Owatonna, MN 55060

RE: Project Number(s) SL30580016

Dear Licensee:

On February 3, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 14, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 14, 2024 survey.

The Department of Health 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.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the February 3, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0900 - Contract Required - 144g.50 Subdivision 1
1540 - Training In Dementia Care Required - 144g.64 (a)
1650 - Service Plan, Implementation And Revisions To - 144g.70 Subd. 4 (f)
1750 - Delegation Of Medication Administration - 144g.71 Subd. 7
2170 - Services For Residents With Dementia - 144g.84 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on February 3, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in

- §144G.20 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
- Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

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.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/03/2025
NAME OF PROVIDER OR SUPPLIER PRAIRIE COTTAGES OF OWATONNA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 150 24TH STREET NE OWATONNA, MN 55060			
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30580016-1 On February 3, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 14, 2024. At the time of the survey, there were 37 residents; 37 receiving services under the Assisted Living with Dementia Care License. As a result of the follow-up survey, the following orders were reissued: 0900, 1540, 1650, 1750 and 2170.	{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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (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	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant 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:	{0 480}	Not reviewed during the survey.		
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.	{0 900}			

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{0 900}	Continued From page 3 (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for one of three 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: R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. R3's record contained a written contract signed by R3 on December 27, 2024. The contract was not signed by the licensee. On February 3, 2025, at 1:31 p.m., executive director (ED)-K reviewed R3's contract and stated	{0 900}			

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{0 900}	Continued From page 4 it was not signed by the licensee. No further information was provided.	{0 900}			
{01540} SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of five employees (unlicensed personnel (ULP)-J) received the required amount of dementia care training in the required time frame. 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	{01540}			

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{01540}	Continued From page 5 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: The licensee had an assisted living with dementia care license. ULP-J was hired on February 4, 2019, to provide direct care and services to the facility's residents. ULP-J's employee record contained a document labeled "Dementia Training" dated January 6, 2025. The document had an area for staff signatures which included two signatures, one of them being ULP-J's. The document did not include any other information besides the title and two signatures. ULP-J's employee record did not include the required two hours of dementia training for each 12 months of employment for the year 2023 or 2024. On February 4, 2025, at 9:58 a.m., clinical nurse supervisor (CNS)-B stated she provided an in-person dementia care training for the ULP on January 6, 2025. CNS-B stated the only documentation she had for the dementia training was the sign in sheet. CNS-B stated ULP-J was one of the signatures on the sign in sheet. CNS-B stated she did not document the topics of the training or the amount of time the training took. CNS-B stated ULP-J's record lacked evidence of the required annual dementia training. The licensee's Assisted Living with Memory Care Dementia Training policy dated June 1, 2023,	{01540}			

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{01540}	Continued From page 6 indicated -direct care employees would complete a minimum of eight hours of initial training on dementia care topics. Initial training would be completed within 80 working hours of the employment start date. -direct care employees would complete a minimum of two hours training on topics related to dementia for each 12 months of employment. No further information was provided.	{01540}			
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	{01650}			

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{01650}	Continued From page 7 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for one of three residents (R5). 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: R5 was admitted on December 30, 2024, with diagnoses that included neurocognitive disorder with Lewy body (disease associated with abnormal deposits of protein and can lead to problems with thinking, movement, behavior, and mood). R5's service plan dated December 30, 2024, indicated R5 received services to included activity assist, AM (morning) cares, bathing, fall prevention/safety checks, PM (evening) cares, blood glucose checks, blood pressure checks, and medication administration. R5's service plan lacked the following content: - the fees for services	{01650}			

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{01650}	Continued From page 8 On February 4, 2025, at 10:02 a.m., clinical nurse supervisor (CNS)-B stated R5's service plan did not include the fees for services. The licensee's Contents of Service Plans policy dated June 6, 2023, indicated the service plan would include: i. Fees for services No further information was provided.	{01650}			
{01750} SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for three of five residents (R1, R2, and R3) for medication administration delegated to unlicensed personnel (ULP).	{01750}			

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{01750}	Continued From page 9 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: R1 R1 was admitted on October 7, 2024, with diagnoses that included vascular dementia (type of dementia that occurs when the brain doesn't receive enough blood flow, which can damage brain tissue and impair cognitive function). R1's service plan dated November 20, 2024, indicated R1 received services to include medication administration. R1's signed prescriber orders dated January 23, 2024, included the following PRN medications: -bisacodyl 10 milligram (mg) suppository; insert one suppository rectally daily as needed -fleet enema; give one enema rectally daily as needed -senna plus; take one tablet by mouth up to two times daily as needed -polyethylene glycol powder; 17 grams daily as needed -Robitussin give 10 milliliters (ml) every 4 hours as needed for dry cough. Do not give if cough is productive (no more than 4 doses in 24 hours) -Tussin expectorant; give two teaspoons (tsp) by mouth every two hours as needed do not exceed	{01750}			

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{01750}	Continued From page 10 four doses in 24 hours -over the counter (OTC) cough drop; give one cough drop by mouth every two hours as needed -geri-lanta suspension; give two teaspoons by mouth every two hours as needed -maalox; give 10 ml by mouth every two hours as needed R1's medication administration record dated February 2025, included the following PRN medications: -PRN Medications for constipation: -bisacodyl 10 milligram (mg) suppository; insert one suppository rectally daily as needed -fleet enema; give one enema rectally daily as needed -senna plus; take one tablet by mouth up to two times daily as needed -polyethylene glycol powder; 17 grams daily as needed PRN Medications for cough: -Robitussin give 10 ml every 4 hours as needed for dry cough. Do not give if cough is productive (no more than 4 doses in 24 hours) -Tussin expectorant; give two teaspoons (tsp) by mouth every two hours as needed do not exceed four doses in 24 hours -over the counter (OTC) cough drop; give one cough drop by mouth every two hours as needed PRN Medication for stomach upset and/or heartburn: -geri-lanta suspension; give two teaspoons by mouth every two hours as needed -maalox; give 10 ml by mouth every two hours as needed R2 R2 was admitted on May 14, 2024, with	{01750}			

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{01750}	Continued From page 11 diagnoses that included dementia. R2's service plan dated November 21, 2024, indicated R2 received services to include medication administration. R2's signed prescriber orders dated October 31, 2024, included the following PRN medications: -Robitussin give 10 ml every 4 hours as needed for dry cough. Do not give if cough is productive (no more than 4 doses in 24 hours) -over the counter (OTC) cough drop; give one cough drop by mouth every two hours as needed R2's MAR dated February 2025, included the following PRN medications: PRN Medications for cough: -Robitussin give 10 ml every 4 hours as needed for dry cough. Do not give if cough is productive (no more than 4 doses in 24 hours) -over the counter (OTC) cough drop; give one cough drop by mouth every two hours as needed R3 R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. R3's service plan dated December 4, 2024, indicated R3 received services to include medication administration. R3's signed prescriber orders dated October 31, 2024, included: -maalox; give 10 ml by mouth every two hours as needed for stomach discomfort or heartburn -antacid suspension; take 15 ml by mouth every four hours as needed for heartburn R3's MAR dated February 2025, included the following PRN medications:	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/03/2025
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{01750}	Continued From page 12 PRN Medication for stomach upset/heartburn: -maalox; give 10 ml by mouth every two hours as needed for stomach discomfort or heartburn -antacid suspension; take 15 ml by mouth every four hours as needed for heartburn The licensee failed to provide instruction for the ULP to understand which PRN medication for constipation, cough, and stomach upset/heartburn should be used in which order. On February 4, 2025, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated there were no written instructions regarding which PRN medications should be given in which order for R1, R2, and R3's PRN medications as listed above. CNS-B further stated they updated the resident standing house orders for all residents which included which PRN medications to give in which order. CNS-B stated the updated standing house orders were sent to the residents' primary care providers and were waiting for them to be returned with a prescriber signature. The licensee's Individualized Medication, Treatment and Therapy Management Plans policy dated June 1, 2023, indicated the licensee would develop a medication, treatment, and/or therapy management plan for each resident receiving medication management services that would include: -documentation of specific resident instructions relating to the administration of medications No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{01750}			

Minnesota Department of Health

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{02170}	Continued From page 13	{02170}			
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	{02170}			

Minnesota Department of Health

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{02170}	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for four of four residents (R1, R2, R5, and R6) who received services under the assisted living with dementia care license and resided in the secure memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee had an assisted living with dementia care license. On February 3, 2025, at 1:01 p.m., clinical nurse supervisor (CNS)-B stated the licensee implemented the "Basic Resident Information and Profile" document for all residents to gather the required information for the activity evaluation. The surveyor reviewed the Basic Resident information and Profile document and noted it did not address all the required six provisions. R1 R1 was admitted on October 7, 2024, with diagnoses that included vascular dementia (type of dementia that occurs when the brain doesn't receive enough blood flow, which can damage	{02170}			

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{02170}	Continued From page 15 brain tissue and impair cognitive function). R1's service plan dated November 20, 2024, indicated R1 received services to include activity assist, bathing, bed mobility, behavior-resistive with cares, dressing, grooming, fall prevention/safety checks, prosthetic device, repositioning, toileting, blood glucose checks, and medication administration. R1's record included an undated, Basic Resident Information and Profile document. The document was incomplete with many areas left blank. R1's record lacked an individualized written activity evaluation that addressed all six provisions, and an individualized activity plan based on the evaluation. R2 R2 was admitted on May 14, 2024, with diagnoses that included dementia. R2's service plan dated November 21, 2024, indicated R2 received services to include activity assist, bathing, dressing, escorts, fall prevention, grooming, behavior-wandering, toileting, safety checks, and medication administration. R2's record included an undated, Basic Resident Information and Profile document. The document was incomplete with many areas left blank. R2's record lacked an individualized written activity evaluation that addressed all six provisions, and an individualized activity plan based on the evaluation. R5 R5 was admitted on December 30, 2024, with	{02170}			

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{02170}	Continued From page 16 diagnoses that included neurocognitive disorder with Lewy body (disease associated with abnormal deposits of protein and can lead to problems with thinking, movement, behavior, and mood). R5's service plan dated December 30, 2024, indicated R5 received services to included activity assist, AM (morning) cares, bathing, fall prevention/safety checks, PM (evening) cares, blood glucose checks, blood pressure checks, and medication administration. R5's record included an undated, Basic Resident Information and Profile document. R5's record lacked an individualized written activity evaluation that addressed all six provisions, and an individualized activity plan based on the evaluation. R6 R6 was admitted on January 9, 2025, with diagnoses that included dementia. R6's service plan dated January 9, 2025, indicated R6 received services to include activity assist, AM cares, bathing, PM cares, fall prevention/safety checks, transfers/ambulation/mobility, and medication administration. R6's record included a Basic Resident Information and Profile document dated January 9, 2025. The document was incomplete with many areas left blank. R6's record lacked an individualized written activity evaluation that addressed all six provisions, and an individualized activity plan	{02170}			

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{02170}	Continued From page 17 based on the evaluation. On February 4, 2025, at 9:53 a.m., CNS-B stated the Basic Resident Information and Profile document was given to all residents at the time of admission for the resident and/or family to fill out. CNS-B stated she thought the document addressed the required six provisions; however, after review of the document, CNS-B stated it did not include the required content. CNS-B stated once the document was completed the activity plan should be entered into the resident's care plan. CNS-B stated the licensee continued to work on completing this for all residents who resided in memory care. The licensee's Description of Life Enrichment Programs and How Activities are Implemented in ALDC policy dated January 31, 2023, indicated: 1. Each resident would be evaluated for activities. The evaluation must include: a. Past and current interests b. Current abilities and skills c. Emotional and social needs and patterns d. Physical abilities and limitations e. Adaptations necessary for the resident to participate, and f. Identification of activities for behavioral interventions 4. An individualized activity plan will be developed for those receiving assisted living services based on their activity evaluation. The plan will reflect the resident's activity preferences and needs. No further information was provided.	{02170}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 19, 2024

Licensee
Prairie Cottages of Owatonna
150 24th Street Northeast
Owatonna, MN 55060

RE: Project Number(s) SL30580016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 14, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
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0 000	Initial Comments 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: SL30580016-0 On November 12, 2024, through November 14, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 33 residents; 33 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=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 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 interview and record review, the licensee failed to ensure sufficient staffing to meet the needs of one of three residents (R3), who required an as needed (PRN) medication. 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	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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: On November 12, 2024, at 9:55 a.m. during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they provided medication management services to include PRN medications. CNS-B stated not all unlicensed personnel (ULP) were trained and competent to administer medications; they had "med passers" and "non-med passers". On November 12, 2024, at 11:32 a.m., licensed practical nurse (LPN)-D reviewed the current employee roster and indicated which ULP were trained and competent to administer medications by placing a star next to their names. R3 R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. R3's service plan dated January 5, 2024, indicated R3 received medication administration. During an interview on November 12, 2024, at 12:30 p.m., with R3, R3 stated she was not satisfied with the mediation management services she received from the licensee. R3 stated the licensee did not always have staff on site that could administer medications and she would have to wait for a staff member from the "facility down the block" to come over and administer medications to her. R3 further stated that sometimes the staff from the other facility couldn't come over to administer medications to	0 470			

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0 470	Continued From page 3 her for hours after she requested it. R3 stated on November 11, 2024, at approximately 8:00 p.m., she requested a PRN medication and was told she would have to wait until 10:30 p.m., to receive it because the staff from the other facility were busy and not able to come over at that time. R3 stated she did not receive the PRN medication she requested that night. The surveyor reviewed the weekly staff schedule dated November 10, 2024, through November 16, 2024, and noted on November 11, 2024, from 7:00 p.m., to 6:00 a.m., and November 16, 2024, from 10:00 p.m., to 6:00 a.m., the ULP scheduled to work were not trained to administer medications. On November 13, 2024, at 5:16 a.m., the surveyor met with ULP-H and inquired about R3's request for a PRN medication on the night of November 11, 2024. ULP-H stated he was working that night when R3 requested a PRN medication. ULP-H stated he was not trained to administer medications, and neither were the other ULP working at that time. ULP-H stated they called the other facility and requested a ULP who was trained to administer medications come over to assist with R3's request. ULP-H stated the ULP at the other facility told him they were unable to come over until at least 10:30 p.m., because they were busy with their own residents. ULP-H stated when R3 was told she would have to wait until at least 10:30 p.m. for her medication, R3 became upset and stated, "forget about it, I'll be asleep by then" and walked away. ULP-H stated because R3 told him to forget about it they did not have the ULP from the other facility come over to administer R3's medication. ULP-H stated a couple of times a week the licensee would have all "non-med passers" scheduled to work so in	0 470			

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0 470	Continued From page 4 the event a resident required a medication they would have to call the other facility and request assistance. ULP-H stated the ULP from the other facility would come whenever they could, but that usually took 40 minutes or longer for them to be able to respond. On November 14, 2024, at 8:45 a.m., the surveyor reviewed the weekly staff schedule for November 10, 2024, through November 16, 2024, with LALD-A. LALD-A confirmed that on November 11, 2024, from 7:00 p.m., to 6:00 a.m., and on November 16, 2024, from 10:00 p.m., to 6:00 am., the licensee did not have any ULP that could administer medications scheduled. LALD-A stated they have shared ULPs that were trained and competent to administer medications at both facilities. LALD-A stated on the dates the licensee did not have a med passer scheduled, the ULP working were expected to call the sister facility and request one of the shared ULP to come over and administered the medication. LALD-A stated the shared ULP was expected to respond as soon as they were able too. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) 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. (b) For an assisted living facility with a licensed capacity of ten or fewer residents:	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
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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
0 480	Continued From page 5 (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 lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food	0 480			

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0 480	Continued From page 6 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) 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 14, 2024, for the specific Minnesota Food code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and	0 550			

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0 550	Continued From page 7 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's current 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 potential to affect a large portion or all of the residents). The findings include: On November 12, 2024, at approximately 10:30 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the licensee's grievance procedure posted in the	0 550			

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0 550	Continued From page 8 main lobby. Though the posted grievance procedure included the contact information for the Ombudsman for Long-Term Care, and Minnesota Adult Abuse Reporting Center (MAARC), the posting lacked contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On November 12, 2024, at 11:15 a.m., director of quality improvement (DOQI)-C reviewed the posted grievance procedure and stated it did not include the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 630			

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0 630	Continued From page 9 review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three 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: R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. R3's service plan dated January 5, 2024, indicated R1 received assistance with medication administration, escorts, bathing, grooming/personal hygiene, housekeeping, laundry, and activities, R3's service plan was not signed by R3 or the licensee. On November 13, 2024, at 7:31 a.m., the surveyor observed unlicensed personnel (ULP)-G administer medications to R3. R3's IAPP dated November 12, 2024, did not include the following required items: - the resident's risk of abusing other vulnerable adults; - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On November 14, 2024, at 8:35 a.m., clinical	0 630			

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0 630	Continued From page 10 nurse supervisor (CNS)-B stated R3's IAPP did not include the required content as listed above. The licensee's Vulnerable Adult Maltreatment policy dated June 1, 2023, indicated each resident receiving services will have a written individualized abuse prevention plan that will include: a. Resident's potential to abuse another individual/vulnerable adult b. Resident's risk of abusing other vulnerable adults C. Interventions to minimize the risk of abuse to the resident and other vulnerable adults No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650			

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0 650	Continued From page 11 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of three employees (unlicensed personnel (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-F was hired on April 26, 2023, to provide direct care and services to the facility's residents. On November 13, 2024, at 6:07 a.m., the surveyor observed ULP-F check R1's blood sugar and administer insulin. ULP-F's record lacked the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs On November 14, 2024, at 9:35 a.m., licensed	0 650			

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0 650	Continued From page 12 assisted living director (LALD)-A stated ULP-F's record lacked an annual performance review. The licensee's Personnel Records policy dated June 1, 2023, indicated the personnel record for each person would include performance evaluations which identify areas of improvement needed and training needs performance reviews would be conducted at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
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	0 680			

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0 680	Continued From page 13 allowed to work only when trained staff are also working on site. (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 have a written emergency preparedness (EP) plan with all the required content. 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: The licensee's undated, Emergency Preparedness plan was reviewed and lacked the following: - risk assessment which considered hazards like care related emergencies, cyber-attacks, normal supply of essential resources and medical supplies, should consider duration of interruptions, consider emerging infectious diseases (EIDs); - document risk assessment for an all hazards approach, including EIDs as applicable, categorize the various probable risks by likelihood of occurrence, develop strategies for addressing facility and community based risks (evacuation plans, staffing surges/shortages, back-up plans);	0 680			

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0 680	Continued From page 14 - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise On November 14, 2024, at 10:13 a.m., licensed assisted living director (LALD)-A stated the licensee's current EP plan did not include the above content. The licensee's Emergency and Disaster Plan policy, undated, indicated a written emergency and disaster plan is established to meet the health, safety, and security needs of staff and residents during an emergency or disaster situation. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of:	0 900			

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0 900	Continued From page 15 (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for one of three 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	0 900			

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0 900	Continued From page 16 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. R3's record lacked a written contract. On November 11, 2024, at 7:55 a.m., licensed assisted living director (LALD)-A stated R3 should have a signed contract but it could not be located. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950			

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0 950	Continued From page 17 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for right to a designated representative with the required verbiage on a document separate from the contract for three of three residents (R1, R2, and R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a 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: R1 R1 was admitted on October 7, 2024, with diagnoses that included vascular dementia (type of dementia that occurs when the brain doesn't receive enough blood flow, which can damage brain tissue and impair cognitive function).	0 950			

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0 950	Continued From page 18 R1's Resident Agreement dated October 7, 2024, included an area to designate or decline a designated representative; however, the agreement lacked a separate page for designated representative to include the required verbiage. R1's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R2 R2 was admitted on May 14, 2024, with diagnoses that included dementia. R2's Resident Occupancy Agreement dated May 14, 2024, included an area to designate or decline a designated representative; however, it was left blank. The agreement lacked a separate page for designated representative to include the required verbiage. R2's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated	0 950			

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0 950	Continued From page 19 Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." R3 R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. R3's record lacked a written contract. R3's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On November 13, 2024, at 11:47 a.m., director of quality improvement (DOQI)-C stated R1, R2, and R3's record did not have the correct verbiage for designated representative. In addition, DOQI-C stated the page for the designated representative must have accidentally been removed from the printed agreements. DOQI-C further stated the same contract was used for all	0 950			

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NAME OF PROVIDER OR SUPPLIER PRAIRIE COTTAGES OF OWATONNA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 150 24TH STREET NE OWATONNA, MN 55060			
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0 950	Continued From page 20 residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	01370			

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01370	Continued From page 21 cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-H) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-H was hired on January 11, 2024, to provide direct care and services to the facility's residents. ULP-H's employee record lacked evidence of competency evaluation for the following topics: -care and use of hearing aids; and -standby assistance techniques and how to perform them On November 14, 2024, at 9:12 a.m., licensed	01370			

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01370	Continued From page 22 assisted living director (LALD)-A stated ULP-H's record lacked evidence of competency evaluation for the topics listed above. The licensee's Assisted Living Orientation policy dated June 1, 2023, indicated ULP who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test and a skill demonstration: d. care and use of hearing aids g. standby assistance techniques No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced	01380			

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01380	Continued From page 23 by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-H) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-H was hired on January 11, 2024, to provide direct care and services to the facility's residents. ULP-H's employee record lacked evidence of competency evaluation for the following topics: -range of motioning and positioning On November 14, 2024, at 9:12 a.m., licensed assisted living director (LALD)-A stated ULP-H's record lacked evidence of competency evaluation for the topic listed above. The licensee's Assisted Living Orientation policy dated June 1, 2023, indicated ULP who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test and a skill demonstration: bb. range of motion cc. positioning No further information was provided.	01380			

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01380	Continued From page 24	01380			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of three unlicensed personnel	01440			

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01440	Continued From page 25 (ULP-H and ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H ULP-H was hired on January 11, 2024, to provide direct care and services to the facility's residents. ULP-H's employee record lacked documentation of a registered nurse (RN) supervising ULP-H performing a delegated task within 30 days of beginning work with the licensee. ULP-I ULP-I was hired on February 5, 2024, to provide direct care and services to the facility's residents. ULP-I's employee record lacked documentation of a RN supervising ULP-I performing a delegated task within 30 days of beginning work with the licensee. On November 14, 2024, at 9:05 a.m., licensed assisted living director (LALD)-A stated ULP-H and ULP-I's employee record lacked evidence of a 30-day supervision of a delegated task by the RN. The licensee's Supervision of Unlicensed Personnel policy dated June 1, 2023, indicated	01440			

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01440	Continued From page 26 direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned. The registered nurse will directly supervise staff performing delegated nursing tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-I) completed an orientation to assisted living facility licensing requirements and regulations before providing services to residents. 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	01460			

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01460	Continued From page 27 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-I was hired on February 5, 2024, to provide direct care and services to the facility's residents. ULP-I's employee record lacked evidence of orientation to assisted living regulations for any of the required topics, including: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Handling emergencies and using emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - Principles of person-centered planning/service delivery; - Handling of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; and - Review of types of Assisted Living services the employee will provide and provider's scope of license. On November 14, 2024, at 9:06 a.m., licensed assisted living director (LALD)-A stated ULP-I's record lacked evidence of completing orientation to assisted living facility licensing requirements training. LALD-A further stated, ULP-I had been taken off the schedule until he completed the orientation training. The licensee's Assisted Living with Memory Care	01460			

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01460	Continued From page 28 Orientation-All Staff policy dated June 1, 2023, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's	01500			

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01500	Continued From page 29 disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01500			

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01500	Continued From page 30 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-F was hired on April 26, 2023, to provide direct care and services to the facility's residents. On November 13, 2024, at 6:07 a.m., the surveyor observed ULP-F check R1's blood sugar and administer insulin. ULP-F's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - reporting of maltreatment of vulnerable adults under section 626.557; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - review of infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with resident's who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On November 14, 2024, at 9:08 a.m., licensed	01500			

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01500	Continued From page 31 assisted living director (LALD)-A stated ULP-F's record should have evidence of ULP-F's annual training, however, it could not be located. The licensee's Assisted Living with Memory Care Annual Training policy dated June 1, 2023, indicated all assisted living employees will complete annual education on the following topics: - reporting of maltreatment of vulnerable adults under section 626.557 -assisted living bill of rights -infection control techniques used in the home and implementation of infection control standards -effective approaches for problem solving when working with challenging behaviors -effective approaches for communication with resident with dementia, Alzheimer's disease, or related disorders -review of policies and procedures relating to the provision of assisted living services and how to implement them -principles of person-centered planning and service delivery -how person-centered planning and service delivery applies to direct support services provided by staff -emergency and disaster training No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at	01540			

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01540	Continued From page 32 least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-F, ULP-H and ULP-I) received the required amount of dementia care training in the required time frame. 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: The licensee had an assisted living with dementia	01540			

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01540	Continued From page 33 care license. ULP-F ULP-F was hired on April 26, 2023, to provide direct care and services to the facility's residents. On November 13, 2024, at 6:07 a.m., the surveyor observed ULP-F check R1's blood sugar and administer insulin. ULP-F's employee record did not include the required two hours of dementia training for each 12 months of employment. ULP-H ULP-H was hired on January 11, 2024, to provide direct care and services to the facility's residents. ULP-H's employee record contained evidence the employee received seven and a half hours of dementia care training, not the required eight hours of training within 80 working hours of the employment start date. ULP-I ULP-I was hired on February 5, 2024, to provide direct care and services to the facility's residents. ULP-I's employee record did not include evidence of any initial dementia care training within 80 working hours of the employment start date. On November 14, 2024, at 9:10 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated ULP-F, ULP-H, and ULP-I's records lacked evidence of the required dementia care training as listed above. The licensee's Assisted Living with Memory Care Dementia Training policy dated June 1, 2023,	01540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
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01540	Continued From page 34 indicated -direct care employees would complete a minimum of eight hours of initial training on dementia care topics. Initial training would be completed within 80 working hours of the employment start date. -direct care employees would complete a minimum of two hours training on topics related to dementia for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	01620			

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01620	Continued From page 35 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted timely ongoing nursing assessments for two of three residents (R2 and 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: R2 R2 was admitted on May 14, 2024, with diagnoses that included dementia. R2's service plan dated May 14, 2024, indicated R2 received services to include grooming/hygiene, dressing, toileting, bathing, escorts, safety checks, medication administration, housekeeping, laundry and activities. R2's ongoing nursing assessments were requested. Assessments dated May 14, 2024, and October 22, 2024, were provided. The October 22, 2024, assessment was completed 161 days after the date of admission, thus exceeding the required reassessment at 14	01620			

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01620	Continued From page 36 calendar days and the ongoing assessments not to exceed 90 days. R3 R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. R3's service plan dated January 5, 2024, indicated R3 received assistance with medication administration, escorts, bathing, grooming/personal hygiene, housekeeping, laundry, and activities, R3's service plan was not signed by R3 or the licensee. R3's ongoing nursing assessments were requested. Assessments dated January 5, 2024, and September 17, 2024, were provided. The September 17, 2024, assessment was completed 256 days after the date of the previous assessment, thus exceeding the required assessment at 14 calendar days, and the ongoing assessments not to exceed 90 days. On November 14, 2024, at 8:17 a.m., licensed assisted living director (LALD)-A stated R2 and R3's assessments were not completed within the required time frame. LALD-A further stated R2 and R3 should also have had 90-day assessments, but no other assessments could be located. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated June 6, 2023, indicated a nurse would complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: -Pre-Admission Assessment -14-day assessment: completed up to 14-days	01620			

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01620	Continued From page 37 after start of services -Ongoing assessment: completed periodically but no less than every 90 days -Change in resident conditions No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01640			

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01640	Continued From page 38 review, the licensee failed to ensure a written service plan was signed and revised to reflect the current services provided for three of three residents (R1, R2, and 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 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: R1 R1 was admitted on October 7, 2024, with diagnoses that included vascular dementia (type of dementia that occurs when the brain doesn't receive enough blood flow, which can damage brain tissue and impair cognitive function). R1's service plan dated November 11, 2024, indicated R1 received services to include medication administration, mobility/transfer assist, exercises, prosthetic device, blood glucose check, repositioning, safety checks and toileting. The service plan was not signed by the licensee. On November 13, 2024, at 6:07 a.m., the surveyor observed unlicensed personnel (ULP)-F check R1's blood sugar and administer insulin. R2 R2 was admitted on May 14, 2024, with diagnoses that included dementia.	01640			

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01640	Continued From page 39 On November 13, 2024, at 6:52 a.m., the surveyor observed ULP-E administer medications to R2. R2's service plan dated May 14, 2024, indicated R2 received services to include grooming/hygiene, dressing, toileting, bathing, escorts, safety checks, medication administration, housekeeping, laundry, and activities. R3's service plan did not include medication set up. R3 R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. On November 13, 2024, at 7:31 a.m., the surveyor observed ULP-G administer medications to R3. R3's service plan dated January 5, 2024, indicated R3 received assistance with medication administration, escorts, bathing, grooming/personal hygiene, housekeeping, laundry, and activities, R3's service plan was not signed by R3 or the licensee. On November 14, 2024, at 8:38 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated R1 and R3's service plans were not signed by the licensee and/or the resident. CNS-B further stated R2 received medication set up services, but it was not included on R2's service plan. The licensee's Contents of Service Plans policy dated June 6, 2023, indicated service plans would have a signature or other authentication by the facility and by the resident.	01640			

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01640	Continued From page 40 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	01650			

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01650	Continued From page 41 Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, and 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 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: R1 R1 was admitted on October 7, 2024, with diagnoses that included vascular dementia (type of dementia that occurs when the brain doesn't receive enough blood flow, which can damage brain tissue and impair cognitive function). R1's service plan dated November 11, 2024, indicated R1 received services to include medication administration, mobility/transfer assist, exercises, prosthetic device, blood glucose check, repositioning, safety checks and toileting. The service plan was not signed by the licensee. R1's service plan lacked the following content: - the fees for services R2 R2 was admitted on May 14, 2024, with diagnoses that included dementia.	01650			

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01650	Continued From page 42 R2's service plan dated May 14, 2024, indicated R2 received services to include grooming/hygiene, dressing, toileting, bathing, escorts, safety checks, medication administration, housekeeping, laundry, and activities. R2's service plan did not include medication set up. R2's service plan lacked the following content: - the fees for services; - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and method to contact the facility: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters R3 R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. R3's service plan dated January 5, 2024, indicated R1 received assistance with medication administration, escorts, bathing, grooming/personal hygiene, housekeeping, laundry, and activities, R3's service plan was not signed by R3 or the licensee.	01650			

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01650	Continued From page 43 R3's service plan lacked the following content: - the fees for services; -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; and -contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and method to contact the facility: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters On November 14, 2024, at 8:41 a.m., clinical nurse supervisor (CNS)-B stated R1, R2, and R3's service plans did not include the required content as listed above. The licensee's Contents of Service Plans policy dated June 6, 2023, indicated the service plan would include: a. A description of the services provided b. Fees for services c. Frequency of each service according to resident assessment and resident preferences d. Schedule and methods of monitoring assessments e. Schedule and methods of monitoring staff providing services	01650			

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01650	Continued From page 44 f. Contingency plan g. A contingency plan that includes a. Action taken if the scheduled service cannot be provided b. Information and method to contact the facility c. Names and contact information of persons the resident wishes to have notified in an emergency d. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition e. Identification of and information on who has authority to sign for the resident in an emergency f. Circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced	01750			

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01750	Continued From page 45 by: Based on observation, interview, and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for three of three residents (R1, R2, and R3) for medication administration delegated to unlicensed personnel (ULP). 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: R1 R1 was admitted on October 7, 2024, with diagnoses that included vascular dementia (type of dementia that occurs when the brain doesn't receive enough blood flow, which can damage brain tissue and impair cognitive function). On November 13, 2024, at 6:07 a.m., the surveyor observed ULP-F check R1's blood sugar and administer insulin. R1's service plan dated November 11, 2024, indicated R1 received services to include medication administration. R1's signed prescriber orders dated January 23, 2024, included the following PRN medications: -bisacodyl 10 milligram (mg) suppository; insert one suppository rectally daily as needed	01750			

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01750	Continued From page 46 -fleet enema; give one enema rectally daily as needed -milk of magnesia suspension; 30 milliliters (ml) by mouth daily as needed -milk of magnesia; give 30 ml by mouth daily as needed (duplicate order) -suppository - Dulcolax to be given as needed if milk of magnesia is ineffective. -Senna plus; take one tablet by mouth up to two times daily as needed -polyethylene glycol powder; 17 grams daily as needed -Robitussin give 10 ml every 4 hours as needed for dry cough. Do not give if cough is productive (no more than 4 doses in 24 hours) -Tussin expectorant; give two teaspoons (tsp) by mouth every two hours as needed do not exceed four doses in 24 hours -over the counter (OTC) cough drop; give one cough drop by mouth every two hours as needed -geri-lanta suspension; give two teaspoons by mouth every two hours as needed -Maalox; give 10 ml by mouth every two hours as needed -Tylenol 650 mg; take two tablets every four hours as needed for pain or temperature over 99 degrees Fahrenheit -Tylenol suppository; administer one suppository as needed for pain or temperature over 99 degrees Fahrenheit R1's medication administration record dated November 2024, included the following PRN medications: -PRN Medications for constipation: -bisacodyl 10 milligram (mg) suppository; insert one suppository rectally daily as needed -fleet enema; give one enema rectally daily as needed -milk of magnesia suspension; 30 milliliters (ml)	01750			

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NAME OF PROVIDER OR SUPPLIER PRAIRIE COTTAGES OF OWATONNA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 24TH STREET NE OWATONNA, MN 55060		
(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
01750	Continued From page 47 by mouth daily as needed -milk of magnesia; give 30 ml by mouth daily as needed (duplicate order) -suppository - Ducal to be given as needed if milk of magnesia is ineffective. -Sienna plus; take one tablet by mouth up to two times daily as needed -polyethylene glycol powder; 17 grams daily as needed -PRN Medications for cough: -Robitussin give 10 ml every 4 hours as needed for dry cough. Do not give if cough is productive (no more than 4 doses in 24 hours) -Tussin expectorant; give two teaspoons (tsp) by mouth every two hours as needed do not exceed four doses in 24 hours -over the counter (OTC) cough drop; give one cough drop by mouth every two hours as needed -PRN Medication for stomach upset and/or heartburn: -geri-lanta suspension; give two teaspoons by mouth every two hours as needed -Maalox; give 10 ml by mouth every two hours as needed -PRN Medication for pain or fever: -Tylenol 650 mg; take two tablets every four hours as needed for pain or temperature over 99 degrees Fahrenheit -Tylenol suppository; administer one suppository as needed for pain or temperature over 99 degrees Fahrenheit R2 R2 was admitted on May 14, 2024, with diagnoses that included dementia. On November 13, 2024, at 6:52 a.m., the surveyor observed ULP-E administer medications	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER PRAIRIE COTTAGES OF OWATONNA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 24TH STREET NE OWATONNA, MN 55060		
(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
01750	Continued From page 48 to R2. R2's service plan dated May 14, 2024, indicated R2 received services to include medication administration. R2's signed prescriber orders dated October 31, 2024, included the following PRN medications: -Robitussin give 10 ml every 4 hours as needed for dry cough. Do not give if cough is productive (no more than 4 doses in 24 hours) -over the counter (OTC) cough drop; give one cough drop by mouth every two hours as needed -acetaminophen 500 mg; take one tablet by mouth twice daily as needed for pain -Tylenol suppository; administer one suppository as needed for pain or temperature over 99 degrees Fahrenheit R2's MAR dated November 2024, included the following PRN medications: --PRN Medications for cough: -Robitussin give 10 ml every 4 hours as needed for dry cough. Do not give if cough is productive (no more than 4 doses in 24 hours) -over the counter (OTC) cough drop; give one cough drop by mouth every two hours as needed -PRN Medication for pain or fever: -acetaminophen 500 mg; take one tablet by mouth twice daily as needed for pain -Tylenol suppository; administer one suppository as needed for pain or temperature over 99 degrees Fahrenheit R3 R3 was admitted on January 5, 2024, with diagnoses that included diabetes and anxiety. On November 13, 2024, at 7:31 a.m., the	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER PRAIRIE COTTAGES OF OWATONNA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 24TH STREET NE OWATONNA, MN 55060		
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01750	Continued From page 49 surveyor observed ULP-G administer medications to R3. R3's service plan dated January 5, 2024, indicated R3 received assistance with medication administration. R3's signed prescriber orders included: -Tylenol 650 mg; take two tablets every four hours as needed for pain or temperature over 99 degrees Fahrenheit, dated October 31, 2024; -Tylenol suppository; administer one suppository as needed for pain or temperature over 99 degrees Fahrenheit, dated October 31, 2024; -acetaminophen 500 mg; take two tablets by mouth four times a day as needed, dated January 11, 2024 R3's MAR dated November 2024, included the following PRN medications: -PRN Medication for pain or fever: -Tylenol 650 mg; take two tablets every four hours as needed for pain or temperature over 99 degrees Fahrenheit -Tylenol suppository; administer one suppository as needed for pain or temperature over 99 degrees Fahrenheit -acetaminophen 500 mg; take two tablets by mouth four times a day as needed The licensee failed to provide instruction for the ULP to understand which PRN medication for constipation, cough, stomach upset/heartburn and pain/fever should be used in which order. On November 14, 2024, at 9:00 a.m., clinical nurse supervisor (CNS)-B stated there were no written instructions regarding which PRN medications should be given in which order for R1, R2, and R3's PRN medications as listed	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER PRAIRIE COTTAGES OF OWATONNA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 24TH STREET NE OWATONNA, MN 55060		
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01750	Continued From page 50 above. CNS-B further stated that they were implementing standing house orders for all residents which they would need to update to include which PRN medications to give in which order. The licensee's Individualized Medication, Treatment and Therapy Management Plans policy dated June 1, 2023, indicated the licensee would develop a medication, treatment, and/or therapy management plan for each resident receiving medication management services that would include: -documentation of specific resident instructions relating to the administration of medications No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content 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	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER PRAIRIE COTTAGES OF OWATONNA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 24TH STREET NE OWATONNA, MN 55060		
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01770	Continued From page 51 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: During the entrance conference on November 12, 2024, at approximately 9:55 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication set up. R2 was admitted on May 14, 2024, with diagnoses that included dementia. On November 13, 2024, at 6:52 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R2. R2's service plan dated May 14, 2024, indicated R2 received assistance with medication administration. R2's signed prescriber orders dated November 8, 2024, included: -warfarin 12.5 milligrams (mg) by mouth on Monday -warfarin 10 mg by mouth on Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday R2's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On November 14, 2024, at 8:42 a.m., licensed	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER PRAIRIE COTTAGES OF OWATONNA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 150 24TH STREET NE OWATONNA, MN 55060		
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01770	Continued From page 52 practical nurse (LPN)- D stated she documented medication set up in a progress note; however, the progress note did not include the name of the medication, quantity of dose, times to be administered, and route of administration. LPN-D further stated she was not aware of this requirement. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
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02170	Continued From page 53 entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R1 and R2) who received services under the assisted living with dementia care license and resided in the secure memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee had an assisted living with dementia care license. R1 R1 was admitted on October 7, 2024, with	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30580	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
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02170	Continued From page 54 diagnoses that included vascular dementia (type of dementia that occurs when the brain doesn't receive enough blood flow, which can damage brain tissue and impair cognitive function). On November 13, 2024, at 6:07 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R1. R1's record lacked an individualized written activity evaluation that addressed all six provision and an individualized activity plan based on the evaluation. R2 R2 was admitted on May 14, 2024, with diagnoses that included dementia. On November 13, 2024, at 6:52 a.m., the surveyor observed ULP-E administer medications to R2. R2's service plan dated May 14, 2024, indicated R2 received services to include grooming/hygiene, dressing, toileting, bathing, escorts, safety checks, medication administration, housekeeping, laundry, and activities. R2's record lacked an individualized written activity evaluation that addressed all six provision and an individualized activity plan based on the evaluation. On November 14, 2024, at 9:00 a.m., licensed assisted living director (LALD)-A stated R1 and R2's record did not include an individualized written activity evaluation or activity plan. LALD-A further stated none of the residents in memory care have an activity evaluation or plan at this time.	02170			

Minnesota Department of Health

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02170	Continued From page 55 The licensee's Description of Life Enrichment Programs and How Activities are Implemented in ALDC policy dated January 31, 2023, indicated: 1. Each resident would be evaluated for activities. The evaluation must include: a. Past and current interests b. Current abilities and skills c. Emotional and social needs and patterns d. Physical abilities and limitations e. Adaptations necessary for the resident to participate, and f. Identification of activities for behavioral interventions 4. An individualized activity plan will be developed for those receiving assisted living services based on their activity evaluation. The plan will reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170			

Type: Full
Date: 11/14/24
Time: 08:46:38
Report: 8044241359

Food and Beverage Establishment Inspection Report

Page 1

Location:

Prairie Cottages of Owatonna
150 24th Street Ne
Owatonna, MN55060
Steele County, 74

Establishment Info:

ID #: 0038713
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074550700
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

No chlorine test kit.

Comply By: 11/15/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Dispenser
Violation Issued: No

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39.2 Degrees Fahrenheit - Location: Egg salad in WIC
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.9 Degrees Fahrenheit - Location: Sliced deli ham in WIC
Violation Issued: No

Type: Full
Date: 11/14/24
Time: 08:46:38
Report: 8044241359
Prairie Cottages of Owatonna

Food and Beverage Establishment
Inspection Report

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Serving fridge
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	1	0

HRD inspection conducted with nurse evaluator Kassie Marking. Inspection report reviewed on site with Jess.

Establishment Info: krystalb@pscminn.com

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044241359 of 11/14/24.

Certified Food Protection Manager Krystal R. Braund

Certification Number: FM97580 Expires: 03/02/25

Inspection report reviewed with person in charge and emailed.

Signed: 
Inspector signed for Jess

Signed: 
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us

Report #: 8044241359

DEPARTMENT OF HEALTH

Minnesota Department of Health

Division of Environmental Health, FPLS

P.O. Box 64975

St. Paul, MN 55164-0975

No. of RF/PHI Categories Out

0

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

11/14/24

Time In

08:46:38

Time Out

Prairie Cottages of Owatonna

Address

150 24th Street Ne

City/State

Owatonna, MN

Zip Code

55060

Telephone

5074550700

License/Permit #

0038713

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in complianceOUT= not in complianceN/O= not observedN/A= not applicableCOS=corrected on-site during inspectionR= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT

N/O

No discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT

N/O

Hands clean & properly washed

9

IN

OUT

N/A

N/O

No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUT

Adequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUT

Food obtained from approved source

12

IN

OUT

N/A

N/O

Food received at proper temperature

13

IN

OUT

Food in good condition, safe, & unadulterated

14

IN

OUT

N/A

N/O

Required records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT

N/A

N/O

Food separated and protected

16

IN

OUT

N/A

Food contact surfaces: cleaned & sanitized

17

IN

OUT

Proper disposition of returned, previously served, reconditioned, & unsafe food

Compliance Status

COS

R

Time/Temperature Control for Safety

18

IN

OUT

N/A

N/O

Proper cooking time & temperature

19

IN

OUT

N/A

N/O

Proper reheating procedures for hot holding

20

IN

OUT

N/A

N/O

Proper cooling time & temperature

21

IN

OUT

N/A

N/O

Proper hot holding temperatures

22

IN

OUT

N/A

Proper cold holding temperatures

23

IN

OUT

N/A

N/O

Proper date marking & disposition

24

IN

OUT

N/A

N/O

Time as a public health control: procedures & records

Consumer Advisory

25

IN

OUT

N/A

Consumer advisory provided for raw/undercooked food

Highly Susceptible Populations

26

IN

OUT

N/A

Pasteurized foods used; prohibited foods not offered

Food and Color Additives and Toxic Substances

27

IN

OUT

N/A

Food additives: approved & properly used

28

IN

OUT

Toxic substances properly identified, stored, & used

Conformance with Approved Procedures

29

IN

OUT

N/A

Compliance with variance/specialized process/HACCP

Risk factors (RF) are improper practices or proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is not in compliance

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection

R= repeat violation

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

Non-food contact surfaces clean

Physical Facilities

50

Hot & cold water available; adequate pressure

51

Plumbing installed; proper backflow devices

52

Sewage & waste water properly disposed

53

Toilet facilities: properly constructed, supplied, & cleaned

54

Garbage & refuse properly disposed; facilities maintained

55

Physical facilities installed, maintained, & clean

56

Adequate ventilation & lighting; designated areas used

57

Compliance with MCIAA

58

Compliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date:

11/14/24

Inspector (Signature)