Electronically Delivered

April 9, 2026

Licensee
Madonna Towers of Rochester
4001 19th Ave Northwest
Rochester, MN 55901

RE: Project Number(s) SL20211016

Dear Licensee:

On March 30, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 7, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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Electronically Delivered

January 28, 2026

Licensee
Madonna Towers of Rochester
4001 19th Ave Northwest
Rochester, MN 55901

RE: Project Number(s) SL20211016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 7, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20211	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	4001 19TH AVE NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20211016-0 On January 5, 2026, through January 7, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 121 residents; 59 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate order was issued on January 6, 2026, at a level 3/Widespread (I). The licensee took action on January 6, 2026; however, the scope and level remain at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 1 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and 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 the required information related to the grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On January 5, 2026, at 12:45 p.m. during the facility tour, the surveyor observed postings	0 550		

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0 550	Continued From page 2 located in the foyer area by the main floor elevators. A table next to the elevators held various required postings in clear plastic stands. The surveyor noted blank grievance forms posted on a wall in the mailbox area (beyond the other postings). The facility's grievance procedure and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances was not noted. On January 5, 2026, at 2:30 p.m., executive director/licensed assisted living director (ED/LALD)-A stated she was not aware the grievance procedure was not posted, and it had previously been posted in a clear plastic stand up holder along with the other required postings. She further stated there had been a great deal of "moving things around" and suspected someone may have used the clear plastic stand for another need. The licensee failed to post the required information about the facility's grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The	0 650		

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0 650	Continued From page 3 records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-D). 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:	0 650		

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0 650	Continued From page 4 ULP-D ULP-D was hired on February 26, 2016, to provide direct care services to the licensee's residents. On January 5, 2026, at 1:40 p.m., the surveyor observed ULP-D administer oral medications to R5 in his apartment. ULP-D's employee record included performance reviews with the most recent review dated March 27, 2024. ULP-D's employee record lacked evidence of documentation of annual performance reviews since March 27, 2024, that identified areas of improvement needed and training needs. On January 7, 2026, at 3:19 p.m., regional director of housing services (RDHS)-C stated human resources (HR) personnel stated ULP-D's performance review had been completed and a reminder was sent in June 2025; however, it had not been signed and returned to HR. The licensee's Personnel policy dated March 3, 2022, indicated the Personnel records for each person would include Performance evaluations which identify areas of improvement needed and training needs [performance reviews must be conducted at least annually]. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 5 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 6, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 6 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 810		

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0 810	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 6, 2026 , for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current, affiliated, and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS) with the assisted living license for two of 114 employees (unlicensed personnel (ULP-M, ULP-K). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on January 6, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 5, 2026, at 12:00 p.m., the surveyor received the licensee's current employee list. On January 5, 2026, at 2:05 p.m., the surveyor received the licensee's NETStudy 2.0 roster for health facility identification (HFID) 20211, as printed on January 5, 2026. On January 5, 2026, at 3:40 p.m., the surveyor requested further clarification of background studies for ULP-M and ULP-K as they were not found on the licensee's NETStudy 2.0 roster.	01290		

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01290	Continued From page 9 BACKGROUND STUDY CLEARANCE ULP-M ULP-M was hired on June 20, 2023, as a dining room server for the licensee's residents. NETStudy 2.0 roster dated January 6, 2026, indicated ULP-M had a cleared and affiliated background study with the licensee on June 23, 2023; however, the roster also indicated ULP-M separated from the facility on July 8, 2023. The licensee failed to ensure ULP-M had a current and eligible background study when he was rehired. On January 6, 2026, at 12:00 p.m., regional director of housing services (RDHS)-C stated there was confusion as to why ULP-M did not have a current and cleared background study. She further stated ULP-M was a current employee and had worked without direct supervision. BACKGROUND STUDY AFFILIATION ULP-K ULP-K was hired on November 11, 2025, as a facility housekeeper. ULP-K's employee record included a cleared background study affiliated with the licensee's skilled nursing facility, and was affiliated with the licensee on January 6, 2026, (when noted during survey). ULP-K's background study lacked affiliation with the licensee's HFID number 20211. The licensee failed to affiliate ULP-K's	01290		

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01290	Continued From page 10 background study to their facility license before having direct contact with residents. On January 6, 2026, at 9:00 a.m., RDHS-C stated ULP-K's background study was not affiliated prior to January 6, 2025 (after survey began). The licensee's Background Checks policy dated 2024, indicated a background check will be completed for all community and Support Center associates, and for volunteers, students/interns, temporary staff, agency staff and independent contractors as set forth in this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took action on January 6, 2026; however, the scope and level remain at l.	01290		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the	01950		

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MADONNA TOWERS OF ROCHESTER	4001 19TH AVE NW ROCHESTER, MN 55901

(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
01950	Continued From page 11 ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of two residents (R2) with compression stockings. 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: On January 5, 2026, at 11:30 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee provided treatments including management of compression stockings. R2 was admitted to the secured memory care unit on February 6, 2025, with diagnoses including unspecified dementia. R2's Service Plan dated July 18, 2025, included the services of donning and removal of compression stockings. On January 6, 2026, at 10:05 a.m., the surveyor	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20211	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	4001 19TH AVE NW ROCHESTER, MN 55901

(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
01950	Continued From page 12 observed unlicensed personnel (ULP)-J assist R2 with medication administration, a transfer from her bed via an EZ stand (mechanical lift) to the bathroom, assisted with toileting, bathing, and dressing, don compression stockings, and a transfer to her BRODA chair (specialized wheelchair). ULP-J stated R2 also received services from a hospice agency. R2's medication administration record/treatment administration record (MAR/TAR) dated December 2025, indicated compression stockings, indicating bilateral knee-high compression stockings for lower extremity edema (swelling) apply in the morning and remove at bedtime. Wash and hang to dry in the evening after removing. R2's signed prescriber's orders dated November 19, 2025, included an order for compression stockings, indicating bilateral knee-high compression stockings for lower extremity edema (swelling), apply in the morning and remove at bedtime. Wash and hang to dry in the evening after removing. R2's record lacked individualized instructions for what ULP should monitor for (redness, open skin) when using compression stockings. On January 7, 2026, at 12:20 p.m. regional director of housing services (RDHS)-C stated a system is in place for the nurses to follow when entering new medications and treatments, which prompt the nurses to enter specific instructions for what ULP need to monitor for and report to nursing. She further stated R2's compression stockings did not include this written instruction as required.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20211	A. BUILDING: _____ B. WING _____	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	4001 19TH AVE NW ROCHESTER, MN 55901

(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
01950	Continued From page 13 The licensee's Treatment and Rehabilitative Therapy Management policy dated March 3, 2022, indicated the individualized treatment and therapy management record will include the following: - Documentation of specific resident instructions relating to the treatments or therapy administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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

Food & Beverage Inspection Report

Establishment Info

Madonna Towers of Rochester
4001 19th Ave NW
Rochester, MN 55901
Olmsted County
Parcel:

Phone: 507-288-3911

License Info

License: HFID 20211

Risk:
License:
Expires on:
CFPM: Theresa Rock
CFPM #: 3001; Exp: 9/19/2028

Inspection Info

Report Number: F1038261002
Inspection Type: Full - Single
Date: 1/6/2026 Time: 10:07:20 AM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

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

I acknowledge receipt of the Rochester District Office inspection report number F1038261002 from 1/6/2026

Linda Jones

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20211016-0	**Date:** January 6, 2026
Facility Name: MADONNA TOWERS OF ROCHESTER	
Facility Address: 4001 19TH AVENUE NW, ROCHESTER, MN 55901	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: Facility didn't have carbon monoxide alarms in the resident rooms or alarms connected to the fire alarm panel at the source of fuel fire appliances.

3. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: Fire door on the 11th floor laundry room didn't close and latch.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

   Comments: The surveyor observed the evacuation plans lacked accurate identification of resident rooms and layout. Some rooms had previous construction to join two single apartments into a double. Exit plan diagrams must be correctly labeled to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

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

   Comments: Surveyor requested all documentation for staff training on the FSEP from the executive director/licensed assisted living director (ED/LALD)-A. ED/LALD-A stated they were filling in for the position and were unable to provide any documentation that training had occurred in the past year.