Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 28, 2026

Madonna Towers of Rochester
4001 19th Avenue Northwest
Rochester, MN 55901

RE: CCN:245153
Cycle Start Date: April 23, 2026

Dear Administrator:

On April 23, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 23, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 23, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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April 28, 2026

Madonna Towers of Rochester
4001 19th Avenue Northwest
Rochester, MN 55901

Re: State Nursing Home Licensing Orders
Event ID: 22E562-H1

Dear Administrator:

The above facility survey was completed on April 23, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion, and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/ rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors' findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health

Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245153	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	**4001 19TH AVENUE NORTHWEST , ROCHESTER, Minnesota, 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) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/20/2026. At the time of this survey, MADONNA TOWERS OF ROCHESTER, INC found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/01/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. MADONNA TOWERS OF ROCHESTER, INC is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (111) construction. In 1979, addition was constructed and was determined to be of Type V (111) construction. In 1998, an addition was added and was determined to be Type II (111). In 2002, an addition was added and was determined to be Type V (111). Because the original building is a Type II (111) and the 2 additions are of the type V (111) of construction and meet the construction type allowed for existing buildings, the facility was surveyed as a Type V (111) building. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of	K0000		05/01/2026

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K0000 Bldg. 01	Continued from page 2 National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/01/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire alarm system testing and maintenance per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 10.4.3, 14.1.1, 14.2.1.1, 14.2.1.2.2, 14.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/20/2026 between 10:30 AM and 1:30 PM, it was revealed by review of available documentation that findings and deficiencies noted in vendor report (02/25/2026), had not yet been resolved / corrected. An interview with the Maintenance Director verified	K0345	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. A detailed description of the corrective action taken or planned to correct the deficiency. Fire alarm system inspection was completed again but by a different vendor. All maintenance and necessary repairs were completed. The new vendor provided documentation showing the system to be functioning correctly. Address the measures that will be put in place to ensure the deficiency doesn’t reoccur. Current vendor contracted to perform periodic inspections will be asked to provide evidence that their technicians have the proper training to conduct the inspection prior to the next scheduled time. If vendor fails to provide this, a new vendor will be secured to complete the required periodic inspections of the fire alarm system.	04/24/2026

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K0345 SS = F Bldg. 01	Continued from page 3 this deficient finding at the time of discovery.	K0345	Continued from page 3 Indicate how the facility plans to monitor future performance to ensure solutions are sustained. All inspections will have the Environmental Services Director and/or designee present to oversee the inspection work to ensure it is done correctly. Identify who is responsible for the corrective actions and monitoring of compliance. Director of Environmental Services and/or Designee	04/24/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 19.7.1.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/20/2026 between 10:30 AM and 1:30 PM, it was revealed by review of available documentation that documentation presented for review exhibited lack of randomness. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. A detailed description of the corrective action taken or planned to correct the deficiency. One year’s worth of fire drills was created using an online tool to ensure the drills are scheduled with the shift, location, date and time being random. Address the measures that will be put in place to ensure the deficiency doesn’t reoccur. Environmental Services Director will review the fire drill schedule at least monthly or more often if needed to ensure there are no scheduling conflicts for the drills to be completed as scheduled. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The random fire drill schedule will be provided to the Quality Committee/QAPI where it will be reviewed at their monthly meetings to ensure	05/01/2026

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K0712 SS = F Bldg. 01		K0712	Continued from page 4 compliance. Identify who is responsible for the corrective actions and monitoring of compliance. Director of Environmental Services and/or Designee and the Quality Committee/QAPI	05/01/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.1.1, 4.1.4, 4.1.4.2. These deficient findings could have a limited impact on the residents within the facility. Findings include: On 04/20/2026 at 1:00 PM, it was revealed by	K0353	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. A detailed description of the corrective action taken or planned to correct the deficiency. Summit Fire Protection Company was brought in to address the issue with the sprinkler head. The sprinkler head was adjusted to a position that aligned with the ceiling tile and the missing escutcheon cover was installed. Address the measures that will be put in place to ensure the deficiency doesn’t reoccur. Sprinkler heads will continue to be inspected on a quarterly basis. Suspended ceilings/ tiles will be visually inspected by EVS staff on a monthly basis. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. EVS Director and/or designee will monitor to ensure completion of the monthly visual inspections and take action on any concerns noted. Identify who is responsible for the corrective actions and monitoring of compliance.	04/30/2026

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K0353 SS = D Bldg. 01	Continued from page 5 observation in the C-Hall Nurses Station that a sprinkler head was missing an escutcheon cover and the head was not properly positioned / aligned to the ceiling tile. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Continued from page 5 Director of Environmental Services and/or Designee	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/23/2026**

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/20/26-4/23/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal	20000		05/20/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/23/2026**

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MADONNA TOWERS OF ROCHESTER	**4001 19TH AVENUE NORTHWEST , ROCHESTER, Minnesota, 55901**

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20000	Continued from page 1 software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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/RULES.	20000		05/20/2026
21375	Infection Control; Program CFR(s): MN Rule 4658.0800 Subp. 1 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper personal protective equipment (PPE) was used during high-contact cares for 1 of 1 resident (R20) reviewed for enhanced barrier precautions (EBP) who had an	21375	Corrected 5/20/2026	05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/23/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	**4001 19TH AVENUE NORTHWEST , ROCHESTER, Minnesota, 55901**

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21375	Continued from page 2 indwelling catheter (R20). Findings include: R20's quarterly Minimum Data Set dated 4/8/26 indicated R20 was cognitively intact, required partial assistance for activities of daily living (hygiene, toileting, transfers, ambulation), and had a urinary catheter. R20's diagnoses list included: neuromuscular dysfunction of bladder, need for assistance with personal care, unsteadiness on feet, muscle weakness, arthritis of knee, and a history of falling. R20's careplan indicated R20 had a urinary catheter that required catheter care "per facility protocol". R20 required extensive assistance from 1 staff member for transfers, bed mobility and activities of daily living. An infection careplan indicated R20 required enhanced barrier precautions related to the presence of an indwelling catheter and to post clear signage on the door or wall outside the resident room indicating the type of precautions and requirement of PPE. The careplan also indicated staff must apply gloves and gowns prior to facility-identified high-contact care activities, discard PPE in designated location following activities, and sanitize hands after PPE removal. R20's April medication administration record printed 4/22/26 indicated foley catheter change monthly, flush catheter with 30 milliliters normal saline or sterile water as needed, record catheter output and complete catheter care every shift. During observation on 4/21/26 at 10:11 a.m., R20 was lying in bed. Catheter tubing was observed extending from under the blankets to a drainage bag located below the bed. An orange sign titled "enhanced barrier precautions" was attached to the door of R20's room. A plastic cabinet containing PPE was located just outside R20's room. During an observation and interview on 4/22/26 at 9:29 a.m., nursing assistant (NA)-B entered R20's room and applied gloves. R20 independently pivot transferred from her wheelchair to the edge of the bed. Without donning a gown, NA-B removed R20's catheter bag from the dignity bag under R20's wheelchair and placed it on a towel located under	21375		05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/23/2026**

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21375	Continued from page 3 R20's bed. NA-B then lifted R20's legs onto the bed and placed a pillow under R20's legs. NA-B then reached over and used both hands to cover R20 with a sheet. NA-B then removed gloves and performed hand hygiene. During an interview, NA-B stated they receive have monthly trainings regarding infection control practices and have routine meetings routinely to "go over anything new." NA-B stated they would wear gloves and a gown if they are performing direct cares for a resident of if they are draining a catheter bag. NA-B stated they do not have to wear gowns when assisting a resident for transfers or adjusting linens. During an interview on 4/23/26 at 9:07 a.m., the facility infection preventionist (IP) stated residents who have chronic wounds, MDROs (multidrug resistant organisms), and indwelling medical devices, such as urinary catheters, require enhanced barrier precautions. If it is determined a resident requires enhanced barrier precautions, a sign is posted on the door of the resident's room, a cart containing PPE is placed outside the room, the careplan is updated, and a "flag" is placed on the electronic medical record indicating EBP is required. The IP confirmed staff are expected to wear PPE during personal contact, transferring, toileting, wound care, and any care involving the indwelling medical device. During an interview on 4/23/26 at 9:39 a.m., the director of nursing confirmed staff are required to wear gowns and gloves when having direct contact with a resident who has a foley catheter in place. A policy titled "enhanced barrier Precautions" revised 4/1/24, indicated the purposed of EBP is "to decrease transmission of CDC-target and other epidemiologically important multidrug-resistant organisms. EBP will be used for residents actively infected or colonized with CDC-targeted and other epidemiolocally important MDROs. Additionally, residents at risk for MDROs, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing will be required to use EBP." The procedure describes the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated. It also refers to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The policy indicated EBP is required for residents with chronic wounds (e.g. pressure	21375		05/20/2026

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21375	Continued from page 4 ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers), regardless of MDRO colonization status. It is also required for residents who have indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator) regardless of MDRO colonization status. High-contact resident care activities are defined as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs/assisting with toileting needs, indwelling medical device care or use, chronic wound care. PPE is described as gloves and gowns prior to the high-contact care activity. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policy and procedures regarding Enhanced Barrier Precautions (EBP) for the resident and provide staff education regarding the policies and educate staff on the appropriate PPE use. They could also do environmental rounds and audits, and re-education anytime EBP are placed. The DON, ICP or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		05/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245153	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

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E0000	Initial Comments On 4/20/26-4/23/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		04/23/2026
F0000	INITIAL COMMENTS On 4/20/26-4/23/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/20/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to	F0880	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	05/20/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245153	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

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F0880 SS = D	Continued from page 1 help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Continued from page 1 The plan of correction is prepared and/or executed in accordance with federal and state law requirements. A detailed description of the corrective action taken or planned to correct the deficiency. NA-B was retrained on the Enhanced Barrier Precautions policy and procedure. Address the measures that will be put in place to ensure the deficiency doesn’t reoccur. All nursing staff have been re-educated on the Infection Control Policies & Procedures with emphasis on the Enhanced Barrier Precautions Policy & Procedure. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Infection Preventionist and/or designee will conduct audits 3x/week for 2 weeks; 2x/week for 2 weeks; and 1x/week for 2 weeks. Audit results will be presented to the Quality Council/QAPI for review to ensure compliance is being achieved. Identify who is responsible for the corrective actions and monitoring of compliance. Director of Nursing and Infection Preventionist	05/20/2026

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F0880 SS = D	Continued from page 2 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper personal protective equipment (PPE) was used during high-contact cares for 1 of 1 residents (R20) reviewed for enhanced barrier precautions (EBP) who had an indwelling catheter (R20). Findings include: R20's quarterly Minimum Data Set dated 4/8/26 indicated R20 was cognitively intact, required partial assistance for activities of daily living (hygiene, toileting, transfers, ambulation), and had a urinary catheter. R20's diagnoses list included: neuromuscular dysfunction of bladder, need for assistance with personal care, unsteadiness on feet, muscle weakness, arthritis of knee, and a history of falling. R20's careplan indicated R20 had a urinary catheter that required catheter care "per facility protocol". R20 required extensive assistance from 1 staff member for transfers, bed mobility and activities of daily living. An infection careplan indicated R20 required enhanced barrier precautions related to the presence of an indwelling catheter and to post clear signage on the door or wall outside the resident room indicating the type of precautions and requirement of PPE. The careplan also indicated staff must apply gloves and gowns prior to facility-identified high-contact care activities, discard PPE in designated location following activities, and sanitize hands after PPE removal.	F0880		05/20/2026

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F0880 SS = D	Continued from page 3 R20's April medication administration record printed 4/22/26 indicated foley catheter change monthly, flush catheter with 30 mililiters normal saline or sterile water as needed, record catheter output and complete catheter care every shift. During observation on 4/21/26 at 10:11 a.m., R20 was lying in bed. Catheter tubing was observed extending from under the blankets to a drainage bag located below the bed. An orange sign titled "enhanced barrier precautions" was attached to the door of R20's room. A plastic cabinet containing PPE was located just outside R20's room. During an observation and interview on 4/22/26 at 9:29 a.m., nursing assistant (NA)-B entered R20's room and applied gloves. R20 independently pivot transferred from her wheelchair to the edge of the bed. Without donning a gown, NA-B removed R20's catheter bag from the dignity bag under R20's wheelchair and placed it on a towel located under R20's bed. NA-B then lifted R20's legs onto the bed and placed a pillow under R20's legs. NA-B then reached over and used both hands to cover R20 with a sheet. NA-B then removed gloves and performed hand hygiene. During an interview, NA-B stated they receive have monthly trainings regarding infection control practices and have routine meetings routinely to "go over anything new." NA-B stated they would wear gloves and a gown if they are performing direct cares for a resident of if they are draining a catheter bag. NA-B stated they do not have to wear gowns when assisting a resident for transfers or adjusting linens. During an interview on 4/23/26 at 9:07 a.m., the facility infection preventionist (IP) stated residents who have chronic wounds, MDROs (multidrug resistant organisms), and indwelling medical devices, such as urinary catheters, require enhanced barrier precautions. If it is determined a resident requires enhanced barrier precautions, a sign is posted on the door of the resident's room, a cart containing PPE is placed outside the room, the careplan is updated, and a "flag" is placed on the electronic medical record indicating EBP is required. The IP confirmed staff are expected to wear PPE during personal contact, transferring, toileting, wound care, and any care involving the indwelling medical device.	F0880		05/20/2026

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F0880 SS = D	Continued from page 4 During an interview on 4/23/26 at 9:39 a.m., the director of nursing confirmed staff are required to wear gowns and gloves when having direct contact with a resident who has a foley catheter in place. A policy titled “enhanced barrier Precautions” revised 4/1/24, indicated the purposed of EBP is “to decrease transmission of CDC-target and other epidemiologically important multidrug-resistant organisms. EBP will be used for residents actively infected or colonized with CDC-targeted and other epidemiolocally important MDROs. Additionally, residents at risk for MDROs, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing will be required to use EBP.” The procedure describes the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated. It also refers to the use of gowns and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The policy indicated EBP is required for residents with chronic wounds (e.g. pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers), regardless of MDRO colonization status. It is also required for residents who have indwelling medical devices (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator) regardless of MDRO colonization status. High-contact resident care activities are defined as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs/assisting with toileting needs, indwelling medical device care or use, chronic wound care. PPE is described as gloves and gowns prior to the high-contact care activity.	F0880		05/20/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/20/2026. At the time of this survey, MADONNA TOWERS OF ROCHESTER, INC found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		05/01/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. MADONNA TOWERS OF ROCHESTER, INC is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1967 and was determined to be of Type II (111) construction. In 1979, addition was constructed and was determined to be of Type V (111) construction. In 1998, an addition was added and was determined to be Type II (111). In 2002, an addition was added and was determined to be Type V (111). Because the original building is a Type II (111) and the 2 additions are of the type V (111) of construction and meet the construction type allowed for existing buildings, the facility was surveyed as a Type V (111) building. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of	K0000		05/01/2026

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K0000 Bldg. 01	Continued from page 2 National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		05/01/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire alarm system testing and maintenance per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 10.4.3, 14.1.1, 14.2.1.1, 14.2.1.2.2, 14.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/20/2026 between 10:30 AM and 1:30 PM, it was revealed by review of available documentation that findings and deficiencies noted in vendor report (02/25/2026), had not yet been resolved / corrected. An interview with the Maintenance Director verified	K0345	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. A detailed description of the corrective action taken or planned to correct the deficiency. Fire alarm system inspection was completed again but by a different vendor. All maintenance and necessary repairs were completed. The new vendor provided documentation showing the system to be functioning correctly. Address the measures that will be put in place to ensure the deficiency doesn’t reoccur. Current vendor contracted to perform periodic inspections will be asked to provide evidence that their technicians have the proper training to conduct the inspection prior to the next scheduled time. If vendor fails to provide this, a new vendor will be secured to complete the required periodic inspections of the fire alarm system.	04/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245153	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	**4001 19TH AVENUE NORTHWEST , ROCHESTER, Minnesota, 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) COMPLETION DATE
K0345 SS = F Bldg. 01	Continued from page 3 this deficient finding at the time of discovery.	K0345	Continued from page 3 Indicate how the facility plans to monitor future performance to ensure solutions are sustained. All inspections will have the Environmental Services Director and/or designee present to oversee the inspection work to ensure it is done correctly. Identify who is responsible for the corrective actions and monitoring of compliance. Director of Environmental Services and/or Designee	04/24/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to document and conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 19.7.1.8. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 04/20/2026 between 10:30 AM and 1:30 PM, it was revealed by review of available documentation that documentation presented for review exhibited lack of randomness. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0712	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. A detailed description of the corrective action taken or planned to correct the deficiency. One year’s worth of fire drills was created using an online tool to ensure the drills are scheduled with the shift, location, date and time being random. Address the measures that will be put in place to ensure the deficiency doesn’t reoccur. Environmental Services Director will review the fire drill schedule at least monthly or more often if needed to ensure there are no scheduling conflicts for the drills to be completed as scheduled. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The random fire drill schedule will be provided to the Quality Committee/QAPI where it will be reviewed at their monthly meetings to ensure	05/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245153	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA TOWERS OF ROCHESTER	4001 19TH AVENUE NORTHWEST , ROCHESTER, Minnesota, 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) COMPLETION DATE
K0712 SS = F Bldg. 01		K0712	Continued from page 4 compliance. Identify who is responsible for the corrective actions and monitoring of compliance. Director of Environmental Services and/or Designee and the Quality Committee/QAPI	05/01/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.1.1, 4.1.4, 4.1.4.2. These deficient findings could have a limited impact on the residents within the facility. Findings include: On 04/20/2026 at 1:00 PM, it was revealed by	K0353	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. A detailed description of the corrective action taken or planned to correct the deficiency. Summit Fire Protection Company was brought in to address the issue with the sprinkler head. The sprinkler head was adjusted to a position that aligned with the ceiling tile and the missing escutcheon cover was installed. Address the measures that will be put in place to ensure the deficiency doesn’t reoccur. Sprinkler heads will continue to be inspected on a quarterly basis. Suspended ceilings/ tiles will be visually inspected by EVS staff on a monthly basis. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. EVS Director and/or designee will monitor to ensure completion of the monthly visual inspections and take action on any concerns noted. Identify who is responsible for the corrective actions and monitoring of compliance.	04/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245153	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/20/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0353 SS = D Bldg. 01	Continued from page 5 observation in the C-Hall Nurses Station that a sprinkler head was missing an escutcheon cover and the head was not properly positioned / aligned to the ceiling tile. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353	Continued from page 5 Director of Environmental Services and/or Designee	04/30/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 15, 2026

Administrator
MADONNA TOWERS OF ROCHESTER
4001 19TH AVENUE NORTHWEST
ROCHESTER, MN 55901

RE: CCN: 245153
Cycle Start Date: April 23, 2026

Dear Administrator:

On April 23, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 15, 2026

Administrator
MADONNA TOWERS OF ROCHESTER
4001 19TH AVENUE NORTHWEST
ROCHESTER, MN 55901

Re: Reinspection Results
Event ID: 22E562-H2

Dear Administrator:

On June 1, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 23, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us