Electronically Delivered

February 17, 2026

Licensee
Madonna Meadows of Rochester
3035 Salem Meadows Drive Southwest
Rochester, MN 55902

RE: Project Number(s) SL30704016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 28, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. 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
	30704	A. BUILDING: _____ B. WING _____	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA MEADOWS OF ROCHESTER	3035 SALEM MEADOWS DR SW ROCHESTER, MN 55902

(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: SL30704016-0 On January 26, 2026, through January 28, 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 61 residents; 61 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of five unlicensed personnel (ULP-C) during medication administration and blood sugar checks. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 26, 2026, at 11:35 a.m., the surveyor observed ULP-C don gloves and complete R1's blood sugar check via fingerstick. Following the	0 510		

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0 510	Continued From page 2 fingerstick and obtaining a drop of blood to the test strip, ULP-C removed the test strip from the glucometer (electronic unit to measure blood sugar) and placed the test strip in the sharps container. ULP-C kept her gloves on and documented the blood sugar results on her tablet's touch screen. ULP-C then removed her gloves, donned a new set of gloves, and administered R1's eye drops. ULP-C removed her gloves, and used her phone to call the registered nurse (RN) to report R1's low blood sugar. The RN instructed ULP-C to administer R1's as needed (PRN) glucose 40% gel. ULP-C left R1's room and went to the medication cart, checked the medication administration record (MAR), opened the medication cart, obtained the tube of glucose gel and measured it per the instructions. ULP-C locked the medication cart, returned to R1's room and administered the glucose gel. ULP-C then returned to the medication cart and documented the glucose administration. ULP-C then moved on to setting up the next resident's medications. At no point following checking R1's blood sugar, handling the test strip, and administering the glucose, did ULP-C sanitize her hands. On January 26, 2026, at 11:45 a.m., ULP-C continued with medication set up (still not having washed or sanitized her hands), entered R2's room and administered R2's five oral medications. ULP-C returned to the medication cart, documented R2's medication administration, and without washing/sanitizing her hands, moved on to set up the next set of medications. On January 26, 2026, at 11:55 a.m., ULP-C referenced the MAR and obtained R3's diclofenac 1% gel (topical pain medication). She then entered R3's room, donned a clean set of gloves,	0 510		

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0 510	Continued From page 3 and squirted an undetermined amount of diclofenac gel on her gloved fingers and applied to R3's lower back. ULP-C removed her gloves and without washing/sanitizing her hands, returned to the medication cart to return the diclofenac gel and documented the medication administration on her tablet. On January 26, 2026, at 12:10 p.m., ULP-C returned to R1's room to complete a repeated blood sugar check following the glucose administration. ULP-C donned gloves, poked R1's finger and obtained a drop of blood and placed it on the test strip within the glucometer. She then removed her gloves and pulled the test strip (containing blood) out with her ungloved fingers and placed the test strip in the sharps container. At this time, the RN called ULP-C on her phone, ULP-C answered the phone, documented the blood sugar result on the tablet and returned to the medication cart. Without washing/sanitizing her hands, opened the medication cart, obtained R1's Novolog insulin, referenced the tablet, locked the medication cart and returned to R1's room. ULP-C donned gloves, prepared the insulin pen and handed it to R1 who self-administered the insulin to her belly. ULP-C removed the insulin needle, placed the needle in the sharps container and removed her gloves. ULP-C then left R1's room (without handwashing/sanitizing), returned to the medication cart, opened the cart, returned the insulin pen, and documented the insulin administration on the tablet. ULP-C failed to wash/sanitize her hands following glove use with blood sugar monitoring (once directly touching the soiled test strip) and following and between each observed resident contact with medication administration.	0 510		

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0 510	Continued From page 4 On January 26, 2026, at 12:18 p.m., the surveyor and ULP-C discussed ULP-C's failure to wash/sanitize hands following blood sugar testing, glove use and in-between each resident direct contact. ULP-C stated, "I forgot to do that." On January 27, 2026, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated she expected staff to wash hands between residents, any blood exposure and following glove use. She further stated, "I tell staff they can never wash their hands too much." The licensee's Hand washing policy dated March 3, 2022, indicated handwashing is one of the best ways to protect residents, yourself, and other staff from getting sick through spread of infection. Handwashing should be done at minimal: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	0 775		

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0 775	Continued From page 5 Based on observation and interview, 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 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 28, 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=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

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0 810	Continued From page 6 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, record review, and interview, 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 810		

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0 810	Continued From page 7 situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 28, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01330		

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01330	Continued From page 8 licensee failed to ensure competency training and evaluations were completed for one of two employees (unlicensed personnel (ULP)-I) prior to providing direct care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-I ULP-I had a hire date of August 21, 2025, to provide direct care services to the licensee's residents. ULP-I's training record lacked the following required training topics prior to providing services: -training on prevention of falls for providers working with the elderly or individuals at risk of falls; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident On January 28, 2026, at 3:15 p.m., licensed assisted living director (LALD)-A stated the licensee had recently transitioned to a new online education platform and believed there was confusion with some of the assigned training for ULP-I. She further stated ULP-I was currently	01330		

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01330	Continued From page 9 completing the missing training. The licensee's Assisted Living Orientation-ULP Staff policy dated March 3, 2022, indicated ULP without a certified nursing assistant (CNA) status would complete training prior to providing direct care including: - fall prevention - basic knowledge of body functioning, changes in body functioning, and injuries or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive and developmental needs of the residents No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is	01540		

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01540	Continued From page 10 complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-I) received the required amount of dementia, mental illness, and de-escalation training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee held an Assisted Living Facility with Dementia Care (ALFDC) license. ULP-I had a hire date of August 21, 2025, to provide direct care services to the licensee's residents. ULP-I's employee record contained evidence of completing eight hours of dementia training and 1.5 hours of mental illness and de-escalation training within 80 hours of work; however, ULP-I failed to complete the required two hours of	01540		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01540	Continued From page 11 mental illness training. On January 28, 2026, at 3:15 p.m., licensed assisted living director (LALD)-A stated the licensee was transitioning to a new online training platform and believed some confusion occurred with ULP-I's training transfer and ULP-I had not completed the last module (0.5 hour) of the mental health training. LALD-A further stated ULP-I had worked greater than 80 hours and was completing the training during her shift today. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three unlicensed personnel (ULP-C) completed insulin administration via a prefilled insulin pen according	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30704	A. BUILDING: _____ B. WING _____	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA MEADOWS OF ROCHESTER	3035 SALEM MEADOWS DR SW ROCHESTER, MN 55902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 12 to manufacturer instructions for one of two residents with insulin (R1). 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: R1 R1 was admitted to the facility on June 6, 2013, with diagnoses including congestive heart failure and type 2 diabetes with insulin dependence. R1's Service Agreement dated April 7, 2025, indicated R1 received services including medication management/administration. R1's signed prescriber's order dated October 30, 2025, indicated Novolog 100 units/milliliter (u/ml) inject 15-30 units under the skin three times daily with meals. Inject 25 units with breakfast, 15 units with noon meal, and 30 units with evening meal. On January 26, 2026, at 12:10 p.m., the surveyor observed ULP-C obtain R1's Novolog insulin Flex Pen, don a pair of gloves, gather an alcohol wipe and new needle. ULP-C then dialed the Flex Pen to two units and squirt the insulin out of the Flex Pen. ULP-C then attached the needle to the Flex Pen, dialed it to 15 units, wiped R1's belly, and handed the Flex Pen to R1 who self-administered the insulin.	01750		

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01750	Continued From page 13 R1's medication administration record (MAR) dated January 2026, included the following step by step instructions for her Novolog Flex Pen: 1. Pull the Pen Cap straight off. Wipe the Rubber Seal with an alcohol swab. 2. Select a new needle. Remove the Paper Tab from the outer Needle Shield. 3. Screw the needle onto the cartridge holder. 4. Keep the outer cap to remove the needle after your injection. 5. Dial the Dose Knob to select 2 units. 6. Hold the Pen so the needle is pointing up and tap cartridge to collect any air at the top. 7. Prime the Pen by pushing the injection button with your thumb. You should see a few drops of insulin. 8. If no insulin is seen, repeat priming according to steps 5 through 7, or contact a nurse. 9. Dial pen to 15 units and give pen to resident to inject under the skin. 10. Assure the resident holds the device on the skin for 10 seconds after the dial is pushed to ensure all insulin is delivered and absorbed. **Call provider if blood sugar is over 400. The licensee failed to ensure the proper procedure was followed for a prefilled insulin Flex Pen by wiping the rubber tip of the pen and priming the pen needle once attached to ensure proper infection control and proper insulin dosing was provided. On January 26, 2026, at 12:10 p.m., the surveyor and ULP-C discussed the surveyor's observation of ULP-C's failure to attach the insulin needle to the Flex Pen prior to priming it. ULP-C stated, "I mixed that up", and further stated she forgot to wipe the pen's rubber tip prior to attaching the new needle.	01750		

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01750	Continued From page 14 On January 27, 2026, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated priming the pen prior to placement of the needle "was an odd thing to do". She further stated every resident who received insulin had step by step written instructions in the MAR for the proper steps to follow in preparing a Flex Pen. Novolog manufacturer's instructions dated February 2015, included instructions for flex pen set up and indicated pull of the pen cap, wipe the rubber stopper with an alcohol swab, place a new needle and turn the dose selector to select two units of insulin to prime the needle prior to dialing to the prescribed amount of insulin. The licensee's Medication, Treatment, and Therapy Administration-Licensed and Unlicensed Personnel policy dated April 22, 2024, indicated medications, treatments, or therapies will be administered according to the "6 Rights": - Right person - Right medication - Right time - Right route (by mouth, eye drops, to the skin, etc.) - Right dose (how many milligrams, drops, etc.) - Right reason Before administration, the resident's identity will be verified ensure administration to correct person occurs. Medication, treatment, or therapy will be administered as directed by the resident's Provider orders, the service plan and MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01760	Continued From page 15	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of eight residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the facility under the licensee's Assisted Living Facility with Dementia	01760		

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01760	Continued From page 16 Care (ALFDC) license on January 28, 2025, with diagnoses including unspecified dementia, history of pulmonary embolism (clot in the lung) and venous thrombosis and embolism (blood clot), lower back pain, depression and obstructive sleep apnea. R3's Service Plan dated December 11, 2025, included the service of medication management/administration. On January 26, 2026, at 11:55 a.m., unlicensed personnel (ULP)-C referenced the medication administration record (MAR) and obtained R3's diclofenac 1% gel (topical pain medication) from the medication cart. She then entered R3's room, donned a clean set of gloves, and squirted an undetermined amount of diclofenac gel on her gloved fingers and applied to R3's lower back. The surveyor observed a rubber band around the diclofenac gel tube; however, no measuring tool was noted. R3's medication administration record (MAR) dated January 2026, indicated she received one oral medication for pain, three supplements, three for high blood pressure, one for sleep, one for acid reflux, one for anxiety/agitation, one for depression, one for significant pain, one for nausea/vomiting, one for constipation, one for urinary retention, one for bladder spasms, one for cholesterol, one blood thinner, two antibiotics (one short term and one long term), one inhaler, and two topical pain medications. R3's signed prescriber's orders dated January 20, 2026, indicated diclofenac 1% gel, apply 4 grams (gm), to back three times daily. The licensee failed to ensure R3 received the	01760		

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01760	Continued From page 17 proper dose of diclofenac gel and failed to utilize the proper measuring tool. On January 26, 2026, at 12:18 p.m., ULP-C stated there usually is a measuring card to measure the dose; and added "I kind of know how much to administer by sight". On January 27, 2026, at 12:25 p.m., clinical nurse supervisor (CNS)-B stated each resident receiving diclofenac gel, should have the designated clear, plastic measuring tool rubber banded to the tube of medication. She further stated the ULP should be using the measuring tool to accurately measure the proper dosage. The licensee's Medication, Treatment and Therapy Administration by Unlicensed Personnel policy dated April 22, 2024, indicated medications, treatment and therapy always need to be administered according to the "6 Rights" including: a. Right person b. Right medication, treatment or therapy c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right chart/record to document that the medication, treatment and therapy was taken No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 18 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include in the service plan a written statement of the treatment or therapy services provided for one of four residents (R6) receiving treatments and further failed to ensure the registered nurse (RN)	01940		

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01940	Continued From page 19 specified, in writing, specific instructions and documented those instructions in the resident record for two of two residents (R2, R6) 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: During the entrance conference on January 26, 2026, at 11:30 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents as prescribed. R2 R2 was admitted to the assisted living with dementia care facility (ALFDC) on February 27, 2025, with diagnoses including hypertensive heart disease with heart failure, and metastatic neoplasm of pelvic bones, sacrum and coccyx with metastasis to the liver and bile duct (cancer spreading to other areas of the body). R2's Service Plan dated September 11, 2025, included the services of donning and removal of compression stockings. On January 27, 2026, at 7:45 a.m., the surveyor observed unlicensed personnel (ULP)-G apply R2's compression stockings to both lower extremities.	01940		

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01940	Continued From page 20 R2's medication administration record/treatment administration record (MAR/TAR) dated January 2026, indicated apply compression wraps to legs bilaterally daily and remove prior to bedtime. R2's signed prescriber's orders dated November 18, 2025, included an order for compression stockings, indicating compression stockings daily and remove at bedtime. R2's record lacked individualized instructions for what ULP should monitor for (redness, open skin) when using compression stockings. R6 R6 was admitted on September 16, 2025, with diagnoses including mild cognitive impairment, rheumatoid arthritis, acute respiratory failure with supplemental oxygen, and anxiety disorder. On January 27, 2026, at 8:35 a.m., the surveyor observed ULP-D prepare and administer R6's oral medications. ULP-D stated R6 had his compression stockings put on earlier in the morning. R6's Service Plan dated December 17, 2025, indicated he received services including assistance with dressing, toileting, hearing device, standby assistance with ambulation, and medication management/administration. R6's MAR dated January 2026, indicated staff to assist resident to apply compression stocking every morning and remove at bedtime. Wash socks in bathroom sink and hang to dry. R6's signed prescriber orders dated December 26, 2025, indicated use compression socks	01940		

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01940	Continued From page 21 during the day. The licensee failed to ensure R6's treatment of compression stockings was included in his Service Plan and included documentation of specific resident instructions relating to what ULP should monitor for (redness, open skin) when using compression stockings. On January 28, 2026, at 1:20 p.m., clinical nurse supervisor (CNS)-B stated due to some initial delays in purchasing R6's compression stockings, the Service Plan was not updated to include R6's compression stockings. CNS-B further stated she was aware of the requirement for instructions for the ULP and had created verbiage to address instructions for compression stockings; however, she had not yet gotten to R2 and R6's record to update as needed. The licensee's Treatment and Therapy Management policy dated August 1, 2023, indicated the individualized treatment and therapy management record will include the following: a. A statement of the type of services that will be provided, b. Documentation of specific resident instructions relating to the treatments or therapy administration, c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		

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

Food & Beverage Inspection Report

Establishment Info

Madonna Meadows of Rochester
3035 Salem Meadows Drive SW
Rochester, MN 55902
Olmsted County
Parcel:

Phone: 507-252-5400

License Info

License: HFID 30704

Risk:
License:
Expires on:
CFPM: Joel Walter
CFPM #: 6426; Exp: 01/15/2028

Inspection Info

Report Number: F8044261032
Inspection Type: Full - Single
Date: 1/27/2026 Time: 1:13:02 PM
Duration: minutes
Announced Inspection: Yes
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.

Food & Beverage General Comment

HRD inspection conducted with nurse evaluator Deborah Jacobson. Inspection report reviewed on site with Alicia.

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 F8044261032 from 1/27/2026

Alicia

Michael DeMars, RS
Public Health Sanitarian 3
michael.demars@state.mn.us

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30704016-0	**Date:** January 28, 2026
Facility Name: MADONNA MEADOWS	
Facility Address: 3035 SALEM MEADOWS DRIVE SW, ROCHESTER, MN 55902	

☒ **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. 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:
   - The door closer was disconnected on the fire door for the dementia care laundry room.
   - The fire door was propped open for the information technology room.
   - The fire door was propped open with a wedge for the mechanical/sprinkler room.
   - The fire door with a magnetic hold open device was propped open with a wedge in the wellness room.
   - Interior laundry room fire doors were propped open.
   - Fire doors were propped open in the building in several locations where remodeling construction work was being completed.
   Fire doors shall be maintained as designed to contain fire and smoke in the event of an emergency.

3. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments:
   - There was a controlled egress locking system installed on all emergency exit doors in the dementia care unit. A wanderguard system was installed on the main entrance door in the assisted living part of the building. Occupants in the dementia care unit would have to pass through two controlled egress doors to exit the building using the main entrance.

- In the assisted living part of the building, a controlled egress locking system installed on the second floor interior exit door above the stairs. A wanderguard system was installed on the main entrance door. Occupants using this interior second floor exit door would have to pass through two controlled egress doors to exit the building using the main entrance.

4. Compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 503.5.3]

   Comments: Oxygen cylinders were stored insecurely on the floor in occupied resident room F11. Oxygen cylinders shall be stored in racks or holders to prevent the cylinders from falling over.

☒ **TAG IDENTIFICATION: 0810**

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

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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: Resident room numbers were not labeled on the emergency evacuation floor plans posted in the common areas of the building. Evacuation floor plans shall include resident room numbers to provide efficient communication for exiting in the event of a fire or similar emergency.

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

   Comments: The surveyor requested records from licensed assisted living director (LALD)-A and maintenance technician (MT)-J for employee training on the fire safety and evacuation plan (FSEP) completed in the past twelve months and at the time of hire. Documentation was provided for an all staff fire safety and evacuation training completed on April 11, 2025. Records for new hire employee emergency preparedness training from a third party were provided. The licensee failed to conduct the site specific FSEP training with employees at the required frequency.