Electronically Delivered

February 11, 2026

Licensee
The Homestead at Rochester
5530 Ballington Road Northwest
Rochester, MN 55901

RE: Project Number(s) SL32647016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders 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 Rapid Response Team / State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-800-337-9238 / 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32647	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32647016-0 On January 20, 2026, through January 22, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 53 residents; 52 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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, Food and Beverage Establishment Inspection Report (FBEIR) dated January 20, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and 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 four unlicensed personnel (ULP-H) during personal cares and medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	0 510		

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0 510	Continued From page 4 The findings include: On January 21, 2026, at 7:20 a.m., the surveyor observed ULP-H don clean gloves, complete R2's urinary catheter bag exchange, from a full bag to a leg bag, and emptied the urine from the full bag into the toilet. ULP-H then continued with the same gloves, to open closet and dresser drawers to gather various clothing items for R2 and assisted R2 to a standing position and escorted him to the bathroom for toileting. ULP-H assisted R2 with placement of R2's belt to his pants, assisted him with dressing and cleansing following toileting. ULP-H then removed his gloves and washed his hands. The licensee failed to ensure removal of gloves and proper handwashing occurred between the steps of urinary catheter management, touching other surfaces and performing other personal care tasks. On January 21, 2026, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated her expectation was for staff to remove gloves, complete proper hand hygiene, reapply gloves, if necessary, prior to touching other surfaces or continuing with other tasks. The licensee's Hand Hygiene policy dated 2024, indicated handwashing with soap and water, alcohol-based hand rub/sanitizer, and surgical hand antisepsis. Hand hygiene should be performed: - Immediately before touching a patient. - Before performance of an aseptic task such as placing an indwelling device or handling invasive medical devices. - Before moving from work on a soiled body site to a clean body site on the same patient.	0 510		

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0 510	Continued From page 5 - After touching a patient or patient's surroundings. - After contact with blood, body fluids, or contaminated surfaces. - Immediately after glove removal." The licensee's Gloves policy dated 2024, indicated to don (put on) clean non-sterile gloves in accordance with Standard and Transmission-based Precautions, (i.e., when anticipating touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin or when a resident is in Transmission-based Precautions). Don clean gloves between tasks and procedures on the same resident after contact with blood, body fluids, secretions, excretions. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. No other 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: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota	0 775		

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0 775	Continued From page 6 Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 21, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 7 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of 55 employees (business office assistant (BOA)-F) was affiliated with the assisted living with dementia care license as required. This had the potential to affect the licensee's 53 current 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 20, 2026, at 12:30 p.m., the surveyor received the licensee's employee roster. BOA-F BOA-F was hired on February 12, 2018, as a business office assistant and had the potential for direct contact with the licensee's residents or resident records. The licensee's Department of Human Services (DHS) NETStudy 2.0 roster dated January 20, 2026, indicated BOA-F had a cleared background study; however, BOA-F was affiliated with the licensee's other health facility identification	01290		

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01290	Continued From page 8 ((HFID) 25044) license. BOA-F's records lacked evidence the licensee affiliated a background study for their assisted living with dementia care facility license (HFID 32647). On January 20, 2026, at 3:05 p.m., human resources manager (HRM)-L stated she oversaw the background studies for all employees who worked between the three licensed sites on campus. HRM-L further stated BOA-F also worked between the various sites in regard to the business office duties. HRM-L stated she would affiliate HRM-L's background clearance to the licensee immediately. The licensee's Pre-employment Background Screening policy dated January 8, 2019, indicated applicants for employment with facilities owned or managed by [licensee name] and its subsidiaries, will receive job offers contingent upon the satisfactory completion of a background screening. The background screening includes a Federal, State and County criminal history search; including OIG, Sex Offender, State and Federal Criminal History Search and Identity Verification. Part of this background screening includes Business Office, Managers, Executive Directors and Resident Director, or new Housing employees that will be living on the [licensee name] site will be screened for a credit history. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 9 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of four residents (R1, R4). 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).	01640		

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01640	Continued From page 10 The findings include: R1 R1 was admitted to the Assisted Living Facility with Dementia Care on March 12, 2024, with diagnoses of unspecified dementia. R1's Service Plan dated March 18, 2024, indicated he received level 2 memory care services which included medication management/administration, verbal cues or hands on assistance with bathing, dressing, grooming, verbal cues for ambulation/transfers, dining set up and observation in the dining room. R1's Service Plan lacked the services of hospice, transfers with a mechanical lift, full assistance with toileting and incontinence needs and hands-on assistance with eating. On January 20, 2026, at 1:45 p.m., the surveyor observed unlicensed personnel (ULP)-D assist ULP-J in transferring R1 from his Broda chair (specialized wheelchair) with use of a Hoyer lift (mechanical lift) to his bed. ULP-D administered one oral medication and one topical pain medication to R1. On January 21, 2026, at 7:55 a.m., the surveyor observed an unknown ULP feeding R1 breakfast at the dining room table. R1's Service Documentation dated January 2026, indicated ULP were providing assistance of one for bed baths, assistance with transfers, checking/changing incontinence briefs, and assistance with feeding. The licensee failed to include the services of hospice, transfers with a Hoyer lift, use of a Broda	01640		

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01640	Continued From page 11 chair, and assistance with feeding on the service plan. On January 22, 2026, at 3:00 p.m., clinical nurse supervisor (CNS)-B stated she was working through updates with R1's Service Plan and he should be at a level 5 at this time, and R1's Service Plan should include the services of hospice, transfers with a Hoyer, use of a Broda chair, and assistance with feeding. R4 R4 began receiving services from the licensee on August 11, 2020, with diagnoses including heart failure. On January 21, 2026, at 11:00 a.m., the surveyor observed ULP-I administer R4's oral medications and assist R4 to the bathroom. ULP-I stated R4 was on hospice, had developed a pressure ulcer that was managed by hospice and the licensee. ULP-I needed assistance with all cares, with transfers and being repositioned at night to off load from the pressure ulcer on her bottom. ULP-I stated the licensee also assisted with R4's indwelling urinary catheter. R4's Service Plan dated September 27, 2024, included the services of hospice, medication management/administration, assistance with dressing, bathing, and grooming, assistance with wheelchair transport, and assistance with urinary catheter management. R4's Service Plan lacked the service of evening and overnight assistance with repositioning and daily wound care. R4's Documentation of Services dated January 2026, indicated Reposition resident in bed every two to three hours during hours of sleep to	01640		

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01640	Continued From page 12 prevent further pressure ulcers. . On January 22, 2026, at 3:30 p.m., CNS-B stated R4's Service Plan needed to be updated, and she was not always getting information with new orders in a timely fashion which then prompted her to update the Service Plan. The licensee failed to ensure R4's service plan was updated, including the service of evening and overnight assistance with repositioning as provided by the licensee. The licensee's Service Plan Development and Content of a Service Plan policy dated August 1, 2021, indicated based on the resident reassessment, service plans are reviewed and revised as needed and would include: - a description of the services to be provided; - fees for services; - frequency of each service according to the resident assessment and resident preference; and - the identification of staff or categories of staff who will provide the services; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications,	01750		

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01750	Continued From page 13 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 specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for two of four residents (R1, R2) for medication administration delegated to unlicensed personnel. 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: R1 R1 was admitted to the Assisted Living Facility with Dementia Care (ALFDC) on March 12, 2024, with diagnoses of unspecified dementia. R1's Service Plan dated March 18, 2024, indicated he received level 2 memory care services which included medication management/administration. On January 20, 2026, at 1:45 p.m., the surveyor	01750		

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01750	Continued From page 14 observed unlicensed personnel (ULP)-D assist ULP-J in transferring R1 from his Broda chair (specialized wheelchair) with use of a Hoyer lift (mechanical lift) to his bed. ULP-D administered one oral medication and one topical pain medication to R1. R1's signed medication orders dated January 1, 2026, indicated scheduled medications including one for mild pain, one for significant pain, one topical pain medication, one oral medication for dementia, one topical pain medication, one for constipation, and one eye drop for glaucoma. R1's signed orders further indicated PRN (as needed) medications including one for anxiety, one for hallucinations, one for significant pain or shortness of breath, one for excessive secretions, one oral medication for constipation, and one rectal suppository for constipation. R1's medication administration record (MAR) dated January 2026, included the following PRN medications: - bisacodyl suppository 10 milligrams (mg), give one suppository every 24 hours as needed for constipation; and - sennoside-docusate 8.6-50 mg, give two tablets orally every day as needed for constipation The licensee did not provide instruction for the ULP to understand which PRN medication for constipation should be used first, second, etc. R2 R2 was admitted to the ALFDC on December 5, 2024, with diagnoses of Alzheimer's disease. R2's Service Plan dated December 5, 2024, included the service of medication management/administration.	01750		

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01750	Continued From page 15 On January 21, 2026, at 8:45 a.m., the surveyor observed ULP-G administer seven oral medications and one topical medication to R2. R2's signed medication orders dated January 6, 2026, indicated scheduled medications including one for mild pain, one for significant pain/shortness of breath, two for dementia, one for the heart, one topical medication for pain, one for constipation, and one for depression. R2's signed orders further indicated PRN medications including one medication for mild pain, one topical medication for pain, one suppository for constipation, two oral medications for constipation, one for anxiety, one for hallucinations/nausea/vomiting, one for excessive secretions, one for significant pain/shortness of breath, , R2's MAR dated January 2026, included the following PRN medications: - MiraLAX 17 grams (gm), give 17 gm with fluids as needed daily for constipation; - sennoside-docusate 8.6-50 mg, give two tablets twice daily as needed for constipation; and - bisacodyl suppository 10 mg, give one suppository every 24 hours as needed for constipation The licensee did not provide instruction for the ULP to understand which PRN medication for constipation should be used first, second, etc. On January 22, 2026, at 12:40 p.m., clinical nurse supervisor (CNS)-B stated the ULP know to call nursing for direction on PRN medications; however, CNS-B stated she was not aware instructions needed to be in writing.	01750		

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01750	Continued From page 16 The licensee's Medication Management Services policy dated July 17, 2023, indicated the RN will orient unlicensed personnel to each resident/client and the resident/client's medication management services in person, orally, in writing, or electronically. The licensee's Documentation of Medication Services on the MAR policy dated March 21, 2023, indicated staff will administer the medication according to the instructions on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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	01760		

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01760	Continued From page 17 review, the licensee failed to ensure medications were administered as ordered for one of eight residents (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 was admitted to the Assisted Living Facility with Dementia Care on March 12, 2024, with diagnoses of unspecified dementia. R1's Service Plan dated March 18, 2024, indicated he received level 2 memory care services which included medication management/administration. On January 20, 2026, at 1:45 p.m., the surveyor observed unlicensed personnel (ULP)-D assist ULP-J in transferring R1 from his Broda chair (specialized wheelchair) with use of a Hoyer lift (mechanical lift) to his bed. ULP-D administered one oral medication and one topical pain medication to R1. When ULP-D prepared R1's diclofenac gel from a tube, she squirted an undetermined amount of gel from the tube to her gloved finger and applied it to R1's bilateral hip areas. When asked about the dosage to be given and how she knew she had the proper dose, ULP-D stated, she "just kind of knew". R1's medication administration record (MAR)	01760		

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01760	Continued From page 18 dated January 2026, indicated he received scheduled medications including one for significant pain/shortness of breath, one for mild pain, one for dementia, one for constipation, and one eye drop for glaucoma. R1's MAR further indicated he received as needed medications including one for significant pain, one for constipation, one for hallucinations, one for anxiety, one for excessive secretions, and one suppository for mild pain. R1's signed prescriber's orders dated November 21, 2025, indicated diclofenac 1% gel, apply 4 grams (gm) three times daily to each hip for pain. The licensee failed to ensure R1 received the proper dose of diclofenac gel and failed to utilize the proper measuring tool. On January 21, 2026, at 10:17 a.m., clinical nurse supervisor (CNS)-B stated she expected the ULP to use the plastic strip included with the diclofenac gel to administer the correct dosage, otherwise it was unknown how much medication was provided to the residents. The licensee's Documentation of Medication Services on the MAR policy dated March 21, 2023, indicated the unlicensed personnel would locate appropriate MAR sheet or e-MAR page for the resident/client. Staff will also refer to the medication profile listing the medication name, strength, description, amount to be given and time of day to be given, as well as the purpose of the medication and any special instructions, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 19 days.	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the required content for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 20, 2026, at 11:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication setup. CNS-B stated she set up medications in medication boxes for a couple residents who self-administered their own medications. CNS-B stated she documented a clinical note with the medication set up but was	01770		

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01770	Continued From page 20 not certain about what content she included. R5's Service Plan dated September 15, 2025, included the service of weekly medication set up by the nurse. R5's medication administration record (MAR) dated January 2026, indicated the following medications were set up by the licensee: -atorvastatin 80 milligrams (mg), one tablet daily for cholesterol; -calcium carbonate 1250 mg, one tablet daily as supplement; -cholecalciferol 25 microgram (mcg), one tablet daily as supplement; -finasteride 5 mg, one tablet daily for prostate; -multivitamin, one tablet daily as supplement; -pantoprazole 40 mg, one tablet daily for acid reflux; -spironolactone 12.5 mg, one tablet daily for heart failure; -tamsulosin 0.4 mg, one tablet daily for prostate; -torsemide 20 mg, one tablet daily for edema; -apixaban 5 mg, one tablet daily for atrial fibrillation (irregular heartbeat); and -metoprolol 50 mg, one tablet twice daily for heart rate control R5's progress notes dated October 23, 2025, through January 19, 2026, included one entry which read, "med set up for one week in Medi-set." The licensee's nurse failed to document medication set up to include documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup.	01770		

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01770	Continued From page 21 On January 22, 2026, at 11:00 a.m., CNS-B stated she was not aware of the required content the nurse needed to document when completing medication set up for the residents. The licensee's Medication Administration - Dosage Box Set Up dated September 8, 2023, indicated when the RN or LPN has completed setting up the medications into the Dosage Box, the nurse will document each individual medication that has been set up on the MAR. Documentation at time of set-up will include: a. Date of set up; b. Name of medication; c. Quantity of dose; d. Times to be administered; e. Route of administration; and f. Name of person completing the medication set up. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 22 (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 on the service plan a written statement of the treatment or therapy services, and further failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for two of four residents (R2, R4) with treatments/delegated tasks. 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).	01940		

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01940	Continued From page 23 The findings include: During the entrance conference on January 20, 2026, 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 on December 5, 2024, with diagnoses of Alzheimer's disease. R2's Service Plan dated December 5, 2024, included the services of hospice, medication management/administration, reminders and cues for toileting, and hands on assistance with dressing and grooming. R2's Service plan lacked the treatment of compression stockings and the delegated task of daily urinary catheter bag exchange and emptying urine each shift. On January 21, 2026, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-H assist R2 from bed and complete a urinary bag exchange from a full-sized overnight bag to a daytime leg bag. R2 was observed to already have his compression stockings put on earlier in the morning. ULP-H proceeded to empty the full urine bag and rinse it with a vinegar/water rinse. ULP-H stated the hospice RN managed R2's catheter replacement, and the licensee staff completed the urine bag exchange daily and emptied the urine bag each shift. R2's Service Documentation dated January 2026, indicated Catheter care: Empty catheter bag every 2-3 hours. At night, change into a big drainage bag. Laminated instructions in bathroom. Vinegar to clean bag in bathroom.	01940		

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01940	Continued From page 24 R2's medication administration record (MAR) dated January 2026, indicated compression socks on in the morning and off in evening daily for edema, swelling in legs. R2's record included signed treatment orders dated November 18, 2025, indicating apply support stockings daily. On January 21, 2025, at 10:30 a.m., the surveyor observed a laminated sign on the wall of R2's bathroom. The sign indicated: - compression stockings, knee high socks should be worn during the daytime, caregivers to help with putting them on; and - (urine) leg bag can be used alone during the daytime. Ensure no kinks in tubing and valve at the bottom is closed. Large overnight bag needs to be connected at night. Rinse with vinegar after disconnecting in the morning. The licensee failed to update R2's Service Plan to include management of R2's urinary catheter and donning and removal of R2's compression stockings.The licensee failed to provide written instruction regarding management of R2's suprapubic catheter, in what the ULP should monitor for and report to nursing (low urine output, presence of blood, cloudy, or foul smelling urine). Furthermore, the licensee's RN did not provide written instruction for R2's compression stockings regarding what to monitor for (redness or open skin) and report to the RN. R4 R4 began receiving services from the licensee on August 11, 2020, with diagnoses including heart failure.	01940		

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01940	Continued From page 25 On January 21, 2026, at 11:00 a.m., the surveyor observed ULP-I administer R4's oral medications and assist R4 to the bathroom. ULP-I stated R4 was on hospice, had developed a pressure ulcer that was managed by hospice and the licensee. R4's wound care had been completed earlier in the morning. ULP-I needed assistance with all cares, with transfers and being repositioned at night to off load from the pressure ulcer on her bottom. The surveyor also observed R4 to have a urinary catheter. ULP-I stated R4 received additional services by hospice who inserted and exchanged R4's indwelling urinary catheter; however, the licensee also assisted with emptying R4's indwelling urinary catheter bag each shift. R4's Service Plan dated September 27, 2024, included the services of hospice, medication management/administration, assistance with dressing, bathing, and grooming, assistance with wheelchair transport, and assistance with urinary catheter management. R4's Service Plan lacked the service of evening and overnight assistance with repositioning and daily wound care. R4's Service Documentation dated January 2026, indicated catheter care each shift. R4's MAR dated January 2026, indicated to change dressing to coccyx every three days or when soiled. Cleanse skin before applying new dressing one time a day every three day(s) for wound care. R4's record included a signed order for wound care dated November 25, 2025, indicating cleanse sacral area, pat dry, apply zinc oxide, and apply mepilex dressing twice weekly and as needed if soiled.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32647	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT ROCHESTER	5530 BALLINGTON ROAD NW ROCHESTER, MN 55901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 26 The licensee failed to include the treatment of wound care on R4's Service Plan and the licensee's RN failed to provide written instructions for R4's sacral wound management to include what ULP should monitor for (redness, foul smelling drainage, change in wound appearance). Furthermore, the licensee's RN failed to provide writtent instructions in what the ULP should monitor for and report to nursing (low urine output, presence of blood, cloudy, or foul smelling urine). On January 22, 2026, at 12:35 p.m., clinical nurse supervisor (CNS)-B stated the above services (management of R2's urinary catheter system and compression stockings, R4's wound care) were not included in their Service Plans and would work to update them right away. CNS-B further stated she was not aware of the requirement for written instructions in what ULP should monitor for and report to nursing regarding treatments or delegated tasks. The licensee's Treatment and Therapy Plan and Services policy dated July 28, 2023, indicated the RN is to develop an individualized treatment and therapy management plan, based on the comprehensive nursing assessment, for each resident/client that needs or requests treatment or therapy management services. This plan will be developed with the resident/client and/or their representative, and this plan will be part of the resident/client's service plan. The licensee's Training of Nursing tasks, Medication Administration, Treatment Administration, or Therapy Tasks by Unlicensed Personnel policy dated July 24, 2023, indicated the RN must have and maintain a system for delegation of nursing tasks or activities to	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32647	A. BUILDING: _____ B. WING _____	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01940	Continued From page 27 unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated task as required by the Nurse Practice Act in sections 148.171 to 148.285, and the five rights of delegation including: - Right task to be delegated - Under the right circumstances -The right person to do the task - The right directions and communication - The right supervision to ensure the task is carried out safely No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		

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

Food & Beverage Inspection Report

Establishment Info

The Homestead at Rochester
5530 Ballington Road NW
Rochester, MN 55901
Olmsted County
Parcel:

Phone: 507-535-2000

License Info

License: HFID 32647

Risk:
License:
Expires on:
CFPM: Joel Stehilk
CFPM #: 118268; Exp: 7/20/2026

Inspection Info

Report Number: F1038261008
Inspection Type: Full - Single
Date: 1/20/2026 Time: 11:52:52 AM
Duration: 60 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 4-500 Equipment Maintenance and Operation
4-501.12 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.
COMMENT:
CUTTING BOARDS SCORED AND DISCOLORED
Comply By: 1/30/2026 Originally Issued On: 1/20/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT:
ARE UNDER TABLE NEEDS TO BE CLEANED
Comply By: 1/23/2026 Originally Issued On: 1/20/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.16 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.
COMMENT:
MOPS NEED TO BE HUNG
Comply By: 1/30/2026 Originally Issued On: 1/20/2026

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 F1038261008 from 1/20/2026

Martin Schuelke
Manager

Rob Davis,
Public Health Sanitarian 2

rob.davis@state.mn.us

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL32647016	**Date:** 1/21/2026
Facility Name: The Homestead at Rochester	
Facility Address: 5530 Ballington Road NW Rochester, MN 55901	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. 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 main kitchen door and salon door did not close and latch under their own power. All fire rated doors to corridor shall close and latch always remain closed.

3. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, 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. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: It was observed that there were not a switch/button present to release the controlled doors in the dementia care wing and the floor above.

4. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2]

   Comments: A power tap were plugged into a power tap in the office by the main kitchen.

5. Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. [Minn. Stat. 144G.45 subd. 2; MSFC 604.6]

   Comments: A switch cover were observed missing in resident room 1131 mechanical room.

6. Required fire protection systems. Fire protection systems required by this code or the International Building Code shall be installed, repaired, operated, tested and maintained in accordance with this code. A fire protection system for which a design option, exception or reduction to the provisions of this code or the International Building Code has been granted shall be considered to be a required system. [Minn. Stat. 144G.45 subd. 2; MSFC 901.4.1]

   Comments: There was a sprinkler head missing in the furnace room by the kitchen on the 2nd floor north wing.

7. Maintaining protection. Materials and firestop systems used to protect membrane and through penetrations in fire-resistance-rated construction and construction installed to resist the passage of smoke shall be maintained. The materials and firestop systems shall be securely attached to or bonded to the construction being penetrated with no openings visible through or into the cavity of the construction. Where the system design number is known, the system shall be inspected to the listing criteria and manufacturer's installation instructions. [Minn. Stat. 144G.45 subd. 2; MSFC 703.1]

   Comments: Garbage chute cover did not have a heat link installed in the chain that holds it open and the chain was loose and would not close and latch. Also, the 2nd floor garbage chute door did not close and latch. The wall to the dining area from the serving kitchens had a serving window cut in them.

8. Abatement of electrical hazards. Identified electrical hazards shall be abated. Identified hazardous electrical conditions in permanent wiring shall be brought to the attention of the responsible code official. Electrical wiring, devices, appliances and other equipment that is modified or damaged and constitutes an electrical shock or fire hazard shall not be used. [Minn. Stat. 144G.45 subd. 2; MSFC 604.1]

   Comments: There were open spaces in the electrical panels P1 and P1-sec. 2 in the main kitchen.