Electronically Delivered

July 6, 2026

Licensee
Charter House
211 2nd Street Northwest
Rochester, MN 55901

RE: Project Number(s) SL30329016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 18, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
0830 - 144g.45 Subd. 3 - Local Laws Apply - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. 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.

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30329	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: SL30329016-0 On June 15, 2026, through June 18, 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 328 residents; 139 receiving services under the Assisted Living Facility 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 June 16, 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		
0 775 SS=I	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 Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 17, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		

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0 800	Continued From page 4	0 800		
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 810		

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0 810	Continued From page 6 review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.	0 830		

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0 830	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 17, 2026 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 830		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan	01620		

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01620	Continued From page 8 prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a	01620		

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01620	Continued From page 9 facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for four of four residents (R2, R3, R7, R13). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 began receiving services on August 20, 2025, with diagnoses including heart failure and kidney failure. R2's Service Plan dated August 22, 2025, indicated he received services including assistance with dressing and bathing, and medication management/administration. R2's Service Plan lacked the service of daily wound care. On June 15, 2026, at 1:20 p.m., the surveyor observed registered nurse (RN)-G complete wound care to R2's upper back. RN-G removed the previous dressing, measured the wound,	01620		

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01620	Continued From page 10 cleansed the wound with normal saline, applied Vaseline and non-stick dressing over the wound and secured it with paper tape. RN-G finished the process by providing R2 with a warm compress to the wound area for 15 minutes. On June 16, 2026, at 12:10 p.m., R2's assessments since admission were requested. R2's comprehensive assessments dated August 21, 2025, September 3, 2025, December 24, 2025, and March 26, 2026, were provided. December 24, 2025, assessment was 112 days after the previous date (12 days late), thus exceeding 90 calendar days. R3 R3 began receiving services on December 14, 2022, with diagnoses including heart failure and kidney failure. R3's Service Plan dated January 26, 2026, and included the services of assistance with bathing, oral care, continuous positive airway pressure (CPAP) (breathing machine for sleep apnea) with supplemental oxygen, compression stockings, assistance with urinary catheter bag emptying and exchange, catheter care, assistance with hearing aids and medication management/administration. R3's Service Plan lacked the service of wound care. On June 15, 2026, at 1:33 p.m., the surveyor observed unlicensed personnel (ULP)-H set up and administer R3's afternoon medications. ULP-H also emptied R3's urinary catheter leg bag. The surveyor observed R2 to have a (CPAP) machine on the bedside table as well as an oxygen concentrator which he shared was connected to the CPAP machine at nighttime. R3 was wearing compression stockings and stated	01620		

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01620	Continued From page 11 staff also assisted with putting a dressing on an area of his back that was a long-standing area of concern for breakdown. On June 16, 2026, at 12:10 p.m., R3's last three assessments were requested. R3's comprehensive assessments dated October 4, 2025, January 15, 2026, and May 15, 2026, were provided. January 15, 2026, assessment was 103 days after the previous date (13 days late); and the May 15, 2026, assessment was 106 days after the previous date (16 days late), thus exceeding 90 calendar days for both assessments. R7 R7 began receiving services on April 6, 2022, with diagnoses including ankylosing spondylitis of the spine (a severe type of spinal stenosis (narrowing), where the nerves of the lower spine become severely compressed causing pain and eventual paralysis). R7's Service Plan dated April 15, 2026, indicated she received services including assistance with bathing, dressing, oral care, medication management/administration, suprapubic catheter (catheter inserted through the lower abdominal wall into the bladder) care/bag management, assistance of two staff for mechanical lift transfers, compression wraps/stockings to both lower extremities, daily weights, and bi-level positive airway pressure (BiPAP) (breathing machine worn for sleep apnea). On June 16, 2026, at 7:00 a.m., the surveyor observed ULP-K complete morning cares, dressing, compression stockings, empty R7's overnight urine bag and exchange to a daytime leg bag, and transfer R7 with the assistance of	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30329	A. BUILDING: _____ B. WING _____	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER HOUSE	211 2ND STREET 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
01620	Continued From page 12 another ULP and a mechanical lift system to her electric wheelchair. R7 stated staff (RN) also assisted with wound care to her scalp and left-hand area and the ULP helped her manage/clean and apply her BiPAP machine at bedtime. R7 further stated she had previously managed her own medications; however, has moved to having the licensee manage ordering/storing and administration. On June 16, 2026, at 12:10 p.m., R7's last three assessments were requested. R7's comprehensive assessments dated October 1, 2025, November 4, 2025, and April 6, 2026, were provided. April 6, 2026, was 153 days after the previous assessment date (63 days late), thus exceeding 90 calendar days. R13 R13 began receiving services on June 27, 2022, with diagnoses including type 2 diabetes with insulin dependence. R13's Service Plan dated June 4, 2026, included medication set up and nurse administration of insulin injections. R13's Service Plan lacked the service of blood sugar checks four times daily. On June 16, 2026, at 10:45 a.m., the surveyor observed registered nurse (RN)-V set up R13's insulin pen, check R13's continuous Libre blood sugar monitoring system for R13's current blood sugar level (174) and calculated R13's insulin dose using her sliding scale dosing, dialed the insulin pen to the proper dose and handed the insulin pen to R13 and observed R13 to inject the insulin into her abdomen. RN-V stated the RN's checked R13's blood sugar four times daily just prior to insulin dosing and further stated the nurses also set up R13's weekly medications.	01620		

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01620	Continued From page 13 On June 16, 2026, at 12:10 p.m., R13's last three assessments were requested. R13's comprehensive assessments dated November 7, 2025, February 13, 2026, and June 4, 2026, were provided. The June 4, 2026, assessment was 111 days after the previous assessment date (21 days late), thus exceeding 90 calendar days. On June 17, 2026, at 3:00 p.m., clinical nurse supervisor (CNS)-B stated the licensee was aware some RN assessments were late and had created a performance improvement plan (PIP) to ensure assessments were completed timely in the future. The licensee's Nursing Assessments of Assisted Living Residents policy dated April 3, 2026, indicated ongoing assessment and monitoring completed as needed based on changes in the needs of the resident (change in condition), and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor expired medications for two of 30 residents (R3, R14). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 16, 2026, at 9:10 a.m., the surveyor reviewed the licensee's second floor medication cart with unlicensed personnel (ULP)-E. ULP-E observed and confirmed the following findings: - R3 acetaminophen 500 milligrams (mg), with an expiration date of March 25, 2026, and 15 remaining tablets in the bubble pack. Clinical nurse supervisor (CNS)-B stated R3's acetaminophen was last given on November 10, 2025. -R3 Senna-S 8.6 mg, with an expiration date of March 25, 2026, with 32 remaining tablets. The card was full. -R14 acetaminophen 500 mg, with an expiration date of May 19, 2026, with eight remaining tablets. CNS-B stated R14's acetaminophen was last given on April 18, 2026. The licensee failed to ensure all medications had not exceeded their expiration date. On June 16, 2026, at 10:00 a.m., CNS-B stated	01890		

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01890	Continued From page 15 the expired medications should have been removed from the medication cart. The licensee's Assisted Living Storage of Medications policy dated February 26, 2026, indicated medications that are discontinued, expired, contaminated, deteriorated, or unlabeled and those that are in containers that are cracked, soiled, or without secure closures, are immediately removed from the locked medication storage area and disposed of in accordance with policies and procedures. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	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; (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	01940		

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01940	Continued From page 16 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 for three of four residents (R2, R3, R13), 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 (R3, R7) 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 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 15,	01940		

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01940	Continued From page 17 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to residents as prescribed. R2 R2 began receiving services on August 20, 2025, with diagnoses including heart failure and kidney failure. R2's Service Plan dated August 22, 2025, indicated he received services including assistance with dressing and bathing, and medication management/administration. R2's Service Plan lacked the service of daily wound care. On June 15, 2026, at 1:20 p.m., the surveyor observed registered nurse (RN)-G complete wound care to R2's upper back. RN-G removed the previous dressing, measured the wound, cleansed the wound with normal saline, applied Vaseline and non-stick dressing over the wound and secured it with paper tape. RN-G finished the process by providing R2 with a warm compress to the wound area for 15 minutes. R2's signed wound care order dated April 22, 2026, indicated cleanse area with vashe, put a thin layer of Vaseline, cover with 4 X 4 gauze and paper tape daily. Warm compress for 15 minutes twice daily to promote drainage and reduce inflammation. R2's treatment administration record (TAR) dated June 2026, indicated cleanse area with vashe, put a thin layer of Vaseline, cover with 4 X 4 gauze and paper tape daily. Warm compress for 15 minutes twice daily to promote drainage and reduce inflammation.	01940		

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01940	Continued From page 18 R2's Service Plan did not include R2's wound care as required. R3 R3 began receiving services on December 14, 2022, with diagnoses including heart failure and kidney failure. R3's Service Plan dated January 26, 2026, and included the services of assistance with bathing, oral care, continuous positive airway pressure (CPAP) with oxygen, compression stockings, assistance with urinary catheter bag emptying and exchange, catheter care, assistance with hearing aids and medication management/administration. R3's Service Plan lacked the service of wound care. On June 15, 2026, at 1:33 p.m., the surveyor observed unlicensed personnel (ULP)-H set up and administer R3's afternoon medications. ULP-H also emptied R3's urinary catheter leg bag. The surveyor observed R3 to have a (CPAP) machine on the bedside table as well as an oxygen concentrator which he shared was connected to the CPAP machine at nighttime. R3 was wearing compression stockings and stated staff also assisted with putting a dressing on an area of his back, which was a long-standing area of concern for breakdown. R3's signed prescriber's orders dated January 22, 2026, included: -CPAP Notes: CPAP Machine (Nasal mask; home settings Bern H20 with heated humidification with 1 liter/minute of oxygen bleed Into CPAP tubing. On at bedtime [HS], off in the morning. Staff to clean per manufacturer guidelines. R3's signed prescriber's orders dated May 31,	01940		

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01940	Continued From page 19 2026, indicated: -apply Mepilex dressing to upper spine every three days until wound is healed R3's TAR dated June 2026, indicated: -apply Mepilex dressing every three days until wound resolved; and -CPAP On at HS. Off In AM: 8 centimeters (cm) water with heated humidification with 1 liter bleed into CPAP two times a day for sleep apnea. Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry on a towel R3's Service Plan did not include R3's wound care. Furthermore, the licensee failed to provide written instruction regarding management of R3's CPAP and oxygen use, or what the ULP should monitor for and report to nursing. R7 R7 began receiving services on April 6, 2022, with diagnoses including ankylosing spondylitis of the spine (a severe type of spinal stenosis (narrowing), where the nerves of the lower spine become severely compressed causing pain and eventual paralysis). R7's Service Plan dated April 15, 2026, indicated she received services including assistance with bathing, dressing, oral care, medication management/administration, suprapubic catheter (catheter inserted through the lower abdominal wall into the bladder) care/bag management, assistance of two staff for mechanical lift transfers, compression wraps/stockings to both lower extremities, daily weights, and bi-level positive airway pressure (BiPAP) (machine used for breathing during sleep). On June 16, 2026, at 7:00 a.m., the surveyor	01940		

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01940	Continued From page 20 observed ULP-K complete morning cares, dressing, compression stockings, empty R7's overnight urine bag and exchange to a daytime leg bag, and transfer R7 with the assistance of another ULP and a mechanical lift system to her electric wheelchair. R7 stated staff (RN) also assisted with wound care to her scalp and left-hand area and the ULP helped her manage/clean and apply her BiPAP machine at bedtime. R7 further stated she had previously managed her own medications; however, has moved to having the licensee manage ordering/storing and administration. R7's signed prescriber orders dated May 19, 2026, included: -BIPAP (Nasal mask; ASV9; PS3-15). On at HS, off in AM: Clean mask frame daily after use with CPAP cleaning wipe of soap and water. Dry well, two times a day for sleep apnea clean mask frame daily staff use with CPAP cleaning wipe or soap and water. -compression stockings or compression wraps, on in the morning and remove in the evening. - 16 French suprapubic catheter changed monthly by clinic and as needed for blockage R7's TAR dated June 2026, indicated; -BIPAP On at HS, off in AM: Clean mask frame daily after use with CPAP cleaning wipe or soap and water. Dry well. -Suprapubic catheter care and management-catheter site care twice daily (AM and HS) wash with soap and water. Empty drainage bag regularly, document urinary output, change bag when cloudy urine, foul urine, or discoloration is present. R7's task record dated June 2026, indicated:	01940		

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01940	Continued From page 21 - empty catheter bag every shift and when full. - compression stockings on in the morning and off at night The licensee failed to provide written instruction regarding management of R7's Bi-PAP, compression stockings, and suprapubic catheter care/site care, and what the ULP should monitor for and report to nursing. R13 R13 began receiving services on June 27, 2022, with diagnoses including type 2 diabetes with insulin dependence. R13's Service Plan dated June 4, 2026, included medication set up and nurse administration of insulin injections. R13's Service Plan lacked the service of blood sugar checks four times daily. On June 16, 2026, at 10:45 a.m., the surveyor observed RN-V set up R13's insulin pen, check R13's continuous Libre blood sugar monitoring system for R13's current blood sugar level (174) and calculated R13's insulin dose using her sliding scale dosing, dialed the insulin pen to the proper dose and handed the insulin pen to R13, and observed R13 to inject the insulin into her abdomen. RN-V stated the RNs checked R13's blood sugar four times daily just prior to insulin dosing, and the nurses also set up R13's weekly medications. R13's MAR dated June 2026, indicated: -Humalog 100 units/milliliter (u/ml), give 12 units subcutaneously (in the skin) three times daily and adjust per current blood sugar and correction scale -Lantus Solostar 100 u/ml, give 13 units subcutaneously each evening. The MAR	01940		

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01940	Continued From page 22 indicated blood sugar check at that evening time dose. R13's task record dated June 2026, read R13 has a Freestyle Libre 3 continuous glucose (blood sugar) monitor. Staff check glucose (blood sugar) with client's (resident) phone four times daily. Client (resident) to change sensor independently. R13's signed prescriber orders dated June 4, 2026, indicated glucose monitoring. Notes: Client (resident) uses a Libre 3 continuous glucose monitor (CGM). Nurses will use client's (resident's) phone to obtain her current glucose level prior to meals and bedtime (four times daily) R13's Service Plan did not include the management of R13's blood sugar monitoring. On June 18, 2026, at 10:15 a.m., CNS-B stated the above listed services were missed being added to those residents' service plans, and the licensee was not consistent with providing written instructions for the unlicensed personnel and when they should contact the nurse for the listed treatments. The licensee's Delegation of Nursing Tasks policy dated May 15, 2025, indicated when needed the RN will provide written instructions for ULP performing the procedure. The licensee's Assisted Living Development and Revision to the Service Plan policy dated February 27, 2026, indicated Revisions to the Service Plan-each resident's service plan is reviewed by the RN whenever changes are needed to the services to be provided because of a change in the resident's condition, after receipt of new or revised orders from the resident's	01940		

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01940	Continued From page 23 physician or other prescribing provider, following an incident, or following the resident's return from a hospital or nursing home. 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

Charter House
211 2ND STREET NW
Rochester, MN 55901
Olmsted County
Parcel:

Phone:

License Info

License: HFID 30329

Risk:
License:
Expires on:
CFPM: Jason Arechigo
CFPM #: 73286; Exp: 12/31/2026

Inspection Info

Report Number: F1038261096
Inspection Type: Full - Single
Date: 6/16/2026 Time: 10:00 PM
Duration: 90 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
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:
MANY CUTTING BOARDS ARE HEAVILY SCORED

Comply By: 7/21/2026 Originally Issued On: 6/16/2026

New Order: 4-600 Cleaning Equipment and Utensils

4-601.11D *Priority Level: Priority 3 CFP#: 51*

MN Rule 4626.0840D Clean or replace the water filter for the vending machine in accordance with the manufacturer's instructions.

COMMENT:
THERE ARE EITHER NO DATES SHOWING REPLACEMENT DATES OR THEY ARE OUT OF DATE.

Comply By: 6/23/2026 Originally Issued On: 6/16/2026

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 F1038261096 from 6/16/2026

Kyriakos Karabatsos
Executive Chef

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

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30329016	**Date:** 6/17/2026
Facility Name: Charter House	
Facility Address: 211 2nd Street NW, Rochester, MN 55901	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; 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. 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: No remote release button or switch was provided to break power to all controlled egress doors. The marked exit door leading to a stairwell in the Northeast corner of the enhanced care floor on level four was locked from the egress side requiring a keypad entry to unlock. Several other doors around the facility were equipped with wander management devices. An approved method to remotely unlock controlled egress doors should be installed and maintained.

3. Delayed 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 and other approved locations. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.8.1]

   Comments: No remote release button or switch was provided to break power to all delayed egress doors. The marked exit door leading out of the restaurant dining area on the first floor was a delayed egress door. An approved method to remotely unlock delayed egress doors should be installed and maintained.

4. When delayed egress doors are present, a sign shall be provided on the door and shall be located above and within 12 inches (305 mm) of the door exit hardware. For doors that swing in the direction of egress, the sign shall read: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS.

   Comments: The delayed egress door leading out of the restaurant dining area on the first floor was not equipped with the required signage indicating the use of the door. Delayed egress doors should be equipped with appropriate signage.

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

   Comments: The facility contained multiple fuel burning appliances including gas operated kitchen appliances and laundry machines. The facility lacked proper carbon monoxide detection. No carbon monoxide detectors were present in any of the resident rooms during the survey. One single station carbon monoxide alarm was installed in the basement laundry room, but a review of the annual fire alarm system inspection failed to indicate any carbon monoxide detection devices connected to the fire alarm panel system. No other carbon monoxide detecting equipment was observed during the survey. Proper carbon monoxide detection should be installed and maintained throughout the facility.

6. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. Required exit accesses, exits, and exit discharges shall be continuously maintained free from obstructions or impediments to full instant use in the case of fire or other emergency. Exits shall discharge directly to the exterior of the building. The *exit discharge* shall be at grade or shall provide a direct path of egress travel to grade. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3, 1031.2, 1028.1]

   Comments: The marked exit door near the loading dock was entirely blocked off by a gate and duct tape which prevented it from being used in an emergency. The exit door was not accessible for use in case of fire or another emergency. The exit door discharged to an unprotected drop of approximately 4 feet without a landing, stairs, guard or other safe means of exit. Facility staff indicated that the steps had been removed to be replaced. The missing stairs resulted in a sheer drop which is unsafe for a means of egress. The exit door was made inoperable and unsafe as it did not discharge safely to grade and was blocked off to be inaccessible. Exits should not be obstructed or blocked and should be maintained in a safe and operable condition at all times.

7. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments:

   The escutcheon was missing from a sprinkler head in the stairwell on floor 21 of the building leaving a gap around the sprinkler head which may interfere with the activation of the head.

   Multiple fire rating placards on fire doors and fire door frame assemblies throughout the facility were missing, painted over, or otherwise obstructed. Fire rating placards should be provided and maintained on fire rating doors and should be maintained legible free of paint or other substances.

   The fire extinguisher cabinet near the loading dock doors was blocked by a scissoring gate and was not readily accessible for use during an emergency. Fire extinguishers should be properly maintained and readily accessible.

   The sprinkler standpipe system did not have a hydraulic information placard attached to the system riser displaying required information. Placards should be supplied and maintained with all relevant data and information on the system.

   The sprinkler head wrench was not present in the box during survey. The sprinkler head box should be maintained in proper condition and organized with all required tools inside.

8. Where panic or fire exit hardware is installed, it shall comply with the following: The maximum unlatching force shall not exceed 15 pounds [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.10.1]

   Comments: The exit doors near the mayo conference center rooms leading to exterior were very difficult to open and required a significant amount of force to push open when tested by the surveyor during the survey. Exit doors should be maintained in proper state of repair and readily openable without excessive force.

9. 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: Several power strips and multiplug adapters were connected in sequence in the bedroom area of resident room 1701. Multiplug adapters should be connected directly to the buildings permanent outlets or receptacles.

10. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

    Comments: An unapproved multiplug adapter was in use in the restroom of resident room 1516 to power multiple devices including a blow dryer, nightlight and a curling iron. Unapproved multiplug adapters should be removed and disused.

11. 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: Multiple fire doors throughout the facility were propped open with door wedges that prevented the doors from closing and latching properly. All fire doors should be maintained free of obstruction such that their self-closing operations are not obstructed.

12. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

    Comments: Most of the resident rooms in the facility had battery powered smoke alarms that were installed over hardwired smoke alarm mounting hardware. Hardwired smoke alarms must be replaced with alarms of the same power supply, with the hardwired connection maintained. The hardwired smoke alarms were not replaced with alarms with the same power supply. The hardwired connections of smoke alarms should be restored and smoke alarms maintained in a state of good repair and operability.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 1; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

    Comments:

    The bathroom cabinet door was disconnected from the hinge in the restroom of resident room 2001. The cabinet should be repaired and maintained in a state of good repair.

The closet doors in the bedroom and hallway of room 2001 were off of the track and were missing handles, making them difficult to operate. The closet doors should be repaired and maintained in a state of good repair.

The bathroom ventilation fan in resident room 1516 did not operate properly and was very loud when tested during the survey. The ventilation fan should be repaired and maintained in a state of good repair.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **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 (FSEP) that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: No specific resident procedures for fires or similar emergencies were provided to the surveyor during the survey. Facility staff indicated that residents are trained on fire safety features in the facility, but that there is no written policy for residents. Residents should be provided with site-specific procedures for evacuation during fire or similar emergencies.

☒ **TAG IDENTIFICATION: 0830**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Facility complies with all state and local governing laws, and codes for fire safety, building, and zoning requirements. [Minn. Stat. 144G.45 subd.3]

   Comments:

   During the survey the surveyor observed several projects that were underway without having plans submitted to the Minnesota Department of Health (MDH) for review. During the survey hardwired smoke alarms were replaced with wireless smoke alarms and wiring in electrical rooms appeared to be newly installed and unfinished. Facility staff stated that work was under way to install a new fire detection system throughout the building to more closely match the systems in place in other facilities owned by the licensee. The surveyor confirmed with the local building department and fire marshal's office that permits had been obtained for this work with the city of Rochester, but proper approval was not obtained from MDH. Further projects including renovations to the front lobby, the removal of stairs at an exit door by the loading dock and the additions of delayed and controlled egress systems were

also not properly submitted for review by MDH. No permits were provided for the installation of controlled and delayed egress doors or the closing of the exit door near the loading dock. Proper permits and plan review should be obtained when required.