Electronically Delivered

October 8, 2025

Licensee
Shorewood Commons
2115 2nd Street Southwest
Rochester, MN 55902

RE: Project Number(s) SL20686016

Dear Licensee:

On August 26, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on May 14, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

July 8, 2025

Licensee
Shorewood Commons
2115 2nd Street Southwest
Rochester, MN 55902

RE: Project Number(s) SL20686016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 14, 2025, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20686	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD COMMONS	2115 2ND STREET SW ROCHESTER, MN 55902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL20686016-0 On May 12, 2025, through May 14, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 80 residents; 80 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate order was issued on May 13, 2025, at a level 2/Widespread (F). The licensee took action on May, 13, 2025; however, the scope and level remains at F.	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 May 12, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 775 SS=E	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 comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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 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). On May 14, 2025, at 9:15 a.m., the surveyor toured the facility with environmental services director (ESD)-G, corporate environmental services director (CESD)-H, licensed assisted living director (LALD)-A and assistant executive director (AED)-I. During the facility tour, the surveyor observed electromagnetic locks with keypads were installed on the emergency exit doors. A signal or switch was not installed that had the capability to break power to these door locks. During the facility tour interview, CESD-H verified the above listed observations and stated the licensee recently became aware of the	0 775		

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0 775	Continued From page 4 requirement for a signal or switch to break power to the controlled egress locked doors. CESD-H stated the licensee had already received a quote to install a push button system to cut power to the controlled egress locking system. CESD-H provided a copy of a quote with the scope of the work listing installation of a push button override for the controlled egress locking system. Controlled egress door locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
0 810 SS=D	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	0 810		

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0 810	Continued From page 5 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required drills. 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). The findings include: On May 14, 2025, regional director of operations (RDO)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP floor plan failed to identify the location of a resident sleeping room. On May 14, 2025, at 9:15 a.m., the surveyor toured the facility with	0 810		

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0 810	Continued From page 6 environmental services director (ESD)-G, corporate environmental services director (CESD)-H, licensed assisted living director (LALD)-A and assistant executive director (AED)-I. During the facility tour, the surveyor observed an occupied resident room with the number 124 posted at the door. The posted floor plan and campus map did not identify this resident room; the room was labeled "Eff". During the facility tour interview, ESD-G and CESD-H stated this room was originally designed to be for respite care but had been converted into a resident room, they did not know the date when this change in use occurred. During an interview on May 14, 2025, at 12:30 p.m., ESD-G and CESD-H verified resident room 124 was not identified on the FSEP floor plans. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees at a frequency of every other month evident by a review of completed fire drill logs. Fire drills were recorded on the following dates: February 20, 2024 May 7, 2024 October 30, 2024 November 6, 2024 November 21, 2024 March 17, 2025 During an interview on May 14, 2025, at 12:30 p.m., RDO-C verified the drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01290	Continued From page 7	01290		
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 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 interview and record review, the licensee failed to ensure one of 23 wait staff (WS-I) had a cleared background study through Department of Human Services (DHS) NETStudy 2.0 prior to providing services. 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:	01290		

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01290	Continued From page 8 WS-I was hired by the licensee on February 2, 2023, as a wait staff with dining services. WS-I's employee record contained a cleared 'Final Registry Results Form' dated January 26, 2023; however, it did not include the DHS Background Study Clearance. DHS NETStudy 2.0 website on May 12, 2025, indicated WS-I was affiliated on January 26, 2023, and direct supervision was required. On May 13, 2025, at 11:10 a.m., regional director of operations (RDO)-C stated WS-I works on-call as wait staff in the kitchen and is currently a college student. WS-I works primarily in the summer months and worked 30 hours between the months of June-December 2024. RDO-I further stated WS-I did not have a cleared background study as required. The licensee's 4.02 Background Studies policy dated December 14, 2022, read: "No employee may provide direct services and have independent direct contact with any residents until acceptable results of the background study have been received." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The licensee took action on May, 13, 2025; however, the scope and level remain at F.	01290		
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	01890		

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01890	Continued From page 9 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an insulin pen included an opened date for one of three residents (R2) with insulin administration and failed to ensure medications bore an original or proper label for one of nine residents (R5) receiving 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, 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: MEDICATION OPEN DATES R2 R2 began receiving services on October 21, 2021, with diagnoses including Parkinson's disease, depression, type 2 diabetes, and congestive heart failure. R2's Service Plans dated October 21, 2021, and May 13, 2025, included the service of medication administration. R2's signed prescriber's orders dated October 14,	01890		

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01890	Continued From page 10 2024, indicated: -Novolog insulin 100 units/milliliter (u/ml), administer subcutaneously (under the skin) 25 units in the morning and 10 units in the evening. On May 13, 2025, at 7:30 a.m., unlicensed personnel (ULP)-E was observed to administer oral medications and prepare and administer 25 units of Novolog insulin. R2's insulin pen lacked an open date. ULP-E stated she did not know where the sticker for the open date was and thought it may have been switched out with an old pen that was discarded. ULP-E stated she would not know when the insulin pen was first opened. On May 13, 2025, at 8:15 a.m., licensed practical nurse (LPN)-B stated she expected staff to include an open date for insulin once opened. MEDICATION LABELING R5 R5 started receiving assisted living services on May 22, 2024, and had diagnoses to include dementia with mood disorder, diabetes, congestive heart failure, COPD (chronic obstructive pulmonary disease), and chronic kidney disease. R5's Service Plan dated November 7, 2024, included the service of medication administration. R5's signed medication orders dated May 29, 2024, included diclofenac 1% gel, apply 2 grams (gm) to right shoulder, collarbone and ribs four times daily. On May 13, 2025, at 7:17 a.m., ULP-E was observed to squirt a small amount of gel to her	01890		

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01890	Continued From page 11 index finger from R5's (unlabeled) diclofenac gel (a topical medication used for pain) tube and applied the gel to his right collar bone area. ULP-E stated she was not sure where the original box for the diclofenac gel was and stated the original box likely bore the proper label. The licensee failed to ensure all prescribed medications included a proper label. On May 13, 2025, at 8:15 a.m., LPN-B stated R5's family sometimes purchased additional diclofenac as was an over-the-counter medication, and proper labeling did not occur. Novolog insulin manufacturer's instructions dated July 2023, indicated discard insulin pen stored at room temperature after 28 days of use, even if insulin remains in the pen. The licensee's Medication Management-Administration and documentation of refusals policy dated July 21, 2023, indicated the staff would verify the correct medication name, dosage, date and time of administration, method and route. The licensee's Medication Storage policy dated July 21, 2023, indicated when medications are managed and stored by [licensee name], medications will be kept securely locked and stored per manufacturer's directions. Medications are stored in tackle boxes. They are labeled with each client's name and room number. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		

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	20686	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD COMMONS	2115 2ND STREET SW ROCHESTER, MN 55902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 12	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the required content for one of one discharged resident (R8). 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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20686	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD COMMONS	2115 2ND STREET SW ROCHESTER, MN 55902

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01910	Continued From page 13 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8's record indicated he began receiving assisted living with dementia care services on January 12, 2022, and was discharged on April 24, 2024. R8's Service Plan dated March 14, 2024, included the service of medication management. R8's Medication Administration Record (MAR) dated April 2024, included one medication for mild pain, one for the heart, one for dementia, two supplements, one for acid reflux, two for hypertension, one for heart failure, one for depression, two for agitation, one for sleep, one for cholesterol, one for allergies, one nasal spray for allergies, and one for migraine headaches. R8's signed discharge orders dated April 26, 2024, indicated R8 received medication administration and included a list of R8's medications at the time of his discharge. R's Discharge Summary dated April 14, 2024, indicated R8 discharged to another memory care facility, medications were reconciled and given to R8's wife. The licensee failed to document in the resident's record the disposition of his medications including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. On May 14, 2025, at 9:55 a.m., licensed practical nurse (LPN)-B stated the usual practice for	01910		

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SHOREWOOD COMMONS	2115 2ND STREET SW ROCHESTER, MN 55902

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01910	Continued From page 14 medications at time of discharge/transfer or death was to complete the designated medication disposition form found in the electronic medical record system (EMR); however, this was not done with R8's medications at time of discharge. The licensee's Medication Disposal policy dated August 3, 2023, indicated staff will document in [licensee EMR] under the Medication Disposition to whom the medications were given to, the time and date and the name of each medication. Signed record from resident or resident's responsible person will be kept for resident's chart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of nine residents (R5) observed during medication administration.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20686	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD COMMONS	2115 2ND STREET SW ROCHESTER, MN 55902

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02320	Continued From page 15 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: R5 started receiving assisted living services on May 22, 2024, and had diagnoses to include dementia with mood disorder, diabetes, congestive heart failure, COPD (chronic obstructive pulmonary disease), and chronic kidney disease. R5's Service Plan dated November 7, 2024, included the service of medication administration. R5's Medication Administration Record (MAR) dated May 2025, included one for gout, one heart, medication, one for cholesterol, three supplements, two for heart failure, one for kidney disease, one for thyroid, two for pain, one for dementia, one for sleep, one for diabetes, two for constipation, and one for COPD. R5's signed medication orders dated May 29, 2024, included diclofenac 1% gel, apply 2 grams (gm) to right shoulder, collarbone and ribs four times daily. On May 13, 2025, at 7:17 a.m., unlicensed personnel (ULP)-E was observed to administer 12 oral medications, one eye drop to both eyes, one inhaler, and applied one pain patch to R5's right ribs. Additionally, ULP-E was observed to	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20686	A. BUILDING: _____ B. WING _____	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD COMMONS	2115 2ND STREET SW ROCHESTER, MN 55902

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02320	Continued From page 16 squirt a small amount of gel to her index finger from R5's (unlabeled) diclofenac gel (a topical medication used for pain) tube and applied the gel to his right collar bone area. When asked how much gel she was to apply, ULP-E stated the MAR indicated 2 grams; however, she just squirted on her finger what she thought was the approximate amount as she did not know where the proper measuring tool was. ULP-E failed to properly measure the diclofenac gel to provide the correct amount (dose) of medication as ordered. On May 13, 2025, at 8:10 a.m., licensed practical nurse (LPN)-B stated R5's diclofenac should have been labeled and had a measuring tool for accurate dosing; however, R5 is allotted a specific monthly quantity and with the current order sometimes he runs out and R5's family brings additional medication bought over the counter likely causing the missing tool and not including a label as required. The licensee's Medication Management-Administration and Documentation policy dated July 21, 2023, indicated for non-oral medications or medications not in Medi-set, staff will verify the correct medication name, dosage, date and time of administration, method and route prior to administration. Additionally, while the unlicensed personnel are verifying the medications before administration and there are any questions or discrepancies, they are to contact the licensed nurse and receive instructions at that time before proceeding. The licensee's Medication-Delegation of Administration policy dated July 21, 2023, indicated the unlicensed personnel will follow the	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 17 administration and documentation policy and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02320		

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

Shorewood Commons
2115 2nd Street SW
Rochester, MN 55902
Olmsted County
Parcel:

Phone: 507-252-9110

License Info

License: HFID 20686

Risk:
License:
Expires on:
CFPM: Timothy Wilcken
CFPM #: FM9139; Exp: 9/7/2025

Inspection Info

Report Number: F1038251015
Inspection Type: Full - Single
Date: 5/12/2025 Time: 10:00 AM
Duration: 60 minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT:
MOLD IN THE ICE MAKER; CAN OPENER DIRTY

Comply By: 5/12/2025 Originally Issued On: 5/12/2025

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:
EXTERIOR OF MICROWAVE IS DIRTY
Comply By: 5/12/2025 Originally Issued On: 5/12/2025

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 F1038251015 from 5/12/2025

Establishment Representative

Rob Davis,
Public Health Sanitarian 2
507-206-2757
rob.davis@state.mn.us

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Temperature Observations/Recordings

Establishment Info

Shorewood Commons
Rochester
County/Group: Olmsted County

Inspection Info

Report Number: F1038251015
Inspection Type: Full
Date: 5/12/2025
Time: 10:00 AM

Food Temperature: Product/Item/Unit: Pork Soup**; Temperature Process:** Cooking
Location: Stove Top at 209 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Eggs**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sliced Cheese**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Apple Slices**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Frozen Vegtibles**; Temperature Process:** Cold-Holding
Location: Walk-in Freezer at 0 Degrees F.
Comment:
Violation Issued?: No

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

Sanitizer Observations/Recordings

Establishment Info

Shorewood Commons
Rochester
County/Group: Olmsted County

Inspection Info

Report Number: F1038251015
Inspection Type: Full
Date: 5/12/2025
Time: 10:00 AM

Sanitizing Equipment: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: Dishwashing Area **Equal To** 200ppm Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Cook Line **Equal To** 200ppm PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1038251015

Food Establishment Inspection Report

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901

No. of Risk Factor/Intervention/Violations	1	Date: 5/12/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:00 AM
Score (optional)		Dur: 60 min

Establishment:	Address:	City/State:	Zip:	Phone:
Shorewood Commons	2115 2nd Street SW	Rochester, MN	55902	507-252-9110
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 20686		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	N/O	Proper eating, tasting, drinking, tobacco use		
7	N/O	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	IN	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
	Safe Food and Water			
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labeled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
	Proper Use of Utensils			
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
	Utensils, Equipment and Vending			
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49	X	Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature)

Follow-up: No Follow-up Date: