



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

October 14, 2025

Licensee

Cottagewood Senior Communities  
4216 55th Street Northwest  
Rochester, MN 55901

RE: Project Number(s) SL20391016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 11, 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.

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

### **STATE CORRECTION ORDERS**

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

### **IMPOSITION OF FINES**

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

Level 1: no fines or enforcement;

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;



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

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

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

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

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

#### **DOCUMENTATION OF ACTION TO COMPLY**

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

#### **REQUESTING A HEARING**

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

To submit a hearing request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. 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](mailto: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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a long horizontal flourish extending to the right.

Jodi Johnson, Supervisor

State Evaluation Team

Email: [Jodi.Johnson@state.mn.us](mailto:Jodi.Johnson@state.mn.us)

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  COTTAGEWOOD SENIOR COMM		STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL20391016-0</p> <p>On September 8, 2025, through September 11, 2025, 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 90 residents; 90 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775			

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  COTTAGEWOOD SENIOR COMM		STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST NW ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	<p>Continued From page 1</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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 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).</p> <p>Findings include: On September 10, 2025, from 10:30 a.m. to 2:30 p.m., the surveyor toured the facility with maintenance coordinator (MC)-J and licensed assisted living director (LALD)-A. During the tour, the surveyor observed:</p> <p>DELAYED EGRESS: Facility delayed egress system was not equipped with a separate de-activate system in the fire command center or other approved location in place to override the system. Delayed egress system meets other MN fire code requirements.</p> <p>CARBON MONOXIDE ALARM Facility has carbon monoxide alarms mounted to the ceilings in most areas where fuel supplied</p>	0 775			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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
0 775	Continued From page 2  appliances are, expect for in the laundry room of the Haven cottage. Rooms that have fuel fired appliances will be equipped with a carbon monoxide detector connected to the fire alarm panel or each resident living area will have a carbon monoxide alarm in accordance with MN State fire code.  During a facility tour on September 10, 2025, at 1:30 p.m., MC-J/LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775			
01620 SS=F	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 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;	01620			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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	<p>Continued From page 3</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(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.</p> <p>(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.</p> <p>(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 facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a timely assessment for a change in condition for two of four residents (R2, R9). Furthermore, the licensee's RN failed to complete accurate assessments of residents' condition/health status for three of four residents (R7, R9, 10).</p>	01620			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  COTTAGEWOOD SENIOR COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST 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	<p>Continued From page 4</p> <p>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).</p> <p>The findings include:</p> <p>On September 8, 2025, at 11:00 a.m. during entrance conference, clinical nurse supervisor (CNS)-B stated the registered nurses (RN) completed assessments at the time of admission, within 14 days following resident admission, and every 90 days. She further stated the RN completed comprehensive assessments for a resident's change in condition with resident changes, hospitalizations, and hospice enrollments.</p> <p>CHANGE IN CONDITION ASSESSMENTS</p> <p>R2</p> <p>R2 was admitted to the facility on March 6, 2025, with diagnoses including neurocognitive disorder with Lewy bodies dementia, delirium, and urinary retention with presence of suprapubic urinary catheter (a catheter placed through the abdomen into the bladder).</p> <p>R2's Service Agreement dated March 6, 2025, included the services of assistance with bathing, grooming, dressing, medication management, behavior management and urinary catheter management (emptying catheter bag and</p>	01620			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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	<p>Continued From page 5</p> <p>catheter bag exchange).</p> <p>On September 8, 2025, at 12:10 p.m., the surveyor observed registered nurse (RN)-C flush R2's suprapubic urinary catheter with 60 milliliters (ml) of normal saline solution. RN-C stated the facility nurses were currently flushing R2's catheter four times daily to manage recent issues with bladder sediment plugging the catheter.</p> <p>R2's progress notes dated July 11, 2025, and July 12, 2025, indicated R2 was hospitalized July 11, 2025, following an unresponsive episode where CPR was performed. R2 returned to the facility July 12, 2025, with a diagnoses of "goiter nodular".</p> <p>R2's after visit summary (AVS) from July 11, 2025, hospitalization was not provided.</p> <p>R2's Master Assessments (known as the licensee's comprehensive RN assessments) dated March 6, 2025, June 16, 2025, and July 15, 2025, were provided. R2's Master Assessment dated July 15, 2025, indicated the assessment was for a change in condition following his hospitalization on July 11-July 12, 2025, which was three days after R2 returned to the facility.</p> <p>On September 11, 2025, at 12:15 p.m., clinical nurse supervisor (CNS)-B stated R2's assessment for a change in condition following his hospitalization was done three days following his return and thought assessments for a change in condition were to be done "as soon as possible," and not necessarily the same day as he returned from the hospital.</p>	01620			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>			
(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	<p>Continued From page 6</p> <p><b>R9</b> R9 was admitted to the facility on May 19, 2022, with diagnoses including major neurocognitive disorder without behavioral disturbance, type 2 diabetes with neuropathy (nerve pain), and history of stroke.</p> <p>R9's Service Agreement dated June 3, 2025, included the services of hospice, two-person assistance with dressing, bathing, toileting, and transfers with mechanical lift, assistance with staff escort, medication management, and assistance with meals. R9's Service Agreement lacked the service of urinary catheter management and wound care.</p> <p>On September 9, 2025, at 7:30 a.m., the surveyor observed RN-G provide wound care to R9's sacral area (lower back/tail bone area). RN-G placed an acetic acid-soaked dressing over R9's sacral area and stated the treatment plan was to keep that dressing in place for two hours and then remove and left open to air within R9's incontinence brief. RN-G stated this process was completed twice daily by the facility nurse or a trained unlicensed personnel. Furthermore, the surveyor observed R9 to have an indwelling urinary catheter in place. RN-G stated R9 had the indwelling catheter placed by hospice and was was used to keep her sacral wound dry from R9's urinary incontinence. RN-G stated the facility staff (nurses and unlicensed personnel) managed the catheter (catheter site care and emptying the bag).</p> <p>R9's Hospice Plan of Care Update dated August 28, 2025, indicated a start date of February 13, 2025, for hospice services.</p>	01620			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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	<p>Continued From page 7</p> <p>R9's Master Assessments dated March 13, 2025, June 17, 2025, and August 28, 2025, were provided.</p> <p>R9's comprehensive RN assessment dated March 13, 2025, indicated the assessment was for a change in condition with the "start of hospice services and change in abilities". The assessment was completed a month after hospice services started, and not with the initiation of hospice services.</p> <p>On September 11, 2025, at 12:15 p.m., CNS-B stated there was not a comprehensive RN assessment completed immediately at the time of hospice enrollment, and the given assessment was correct. CNS-B further stated she had "put things in place" to trigger the completion of a change in condition assessment immediately when hospice enrollment occurred.</p> <p><b>ASSESSMENT ACCURACY</b> R7 R7 was admitted to the facility on October 21, 2021, with diagnoses including dementia, type 2 diabetes, and heart failure.</p> <p>R7's Service Agreement dated February 10, 2025, included the services of assistance with bathing, dressing, grooming, toileting, blood sugar monitoring, compression stockings, medication management and behavior management.</p> <p>On September 8, 2025, at 3:56 p.m., the surveyor observed unlicensed personnel (ULP)-E check R7's blood sugar.</p>	01620			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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	<p>Continued From page 8</p> <p>R7's progress notes dated June 5, 2025, indicated R7 was involved in a resident-to-resident altercation where she yelled at another resident, and pushed him (in the hip area). R7 was struck by the other resident, to which R7 struck him back.</p> <p>R7's Individual Abuse Prevention Plan (IAPP) dated June 6, 2025, page 2, question 4. Does resident pose a risk to abusing others physically (hitting, kicking, punching, pushing, grabbing)? the response indicated "Yes". The IAPP included interventions to redirect the resident to another area to sit where she could not physically engage with other vulnerable adults.</p> <p>R7's Master Assessments dated June 13, 2025, and July 31, 2025, were provided. Both assessments in the section labeled Vulnerabilities and Abuse Prevention, included the following questions and responses:</p> <ul style="list-style-type: none"><li>- 2. Does resident pose a risk to abusing others verbally? The response read, "No".</li><li>- 3. Does resident post a risk to abusing others with threatening behavior? The response read, "No".</li><li>- 4. Does resident pose a risk to abusing others physically (hitting, kicking, punching, pushing, grabbing)? The response read, "No".</li></ul> <p>Even though the licensee updated R7's IAPP on June 6, 2025, and accurately depicted her susceptibility to abusing others including other vulnerable adults; the licensee failed to ensure R7's ensuing assessments accurately reflected R7's susceptibility to abusing others including other vulnerable adults following her altercation with another vulnerable resident.</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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	<p>Continued From page 9</p> <p>On September 11, 2025, at 12:10 p.m., CNS-B stated R7's comprehensive RN assessments should mirror the IAPP; however, R7's assessments following her resident-to-resident altercation did not.</p> <p>R9 R9's progress notes written by various facility nurses dated August 7, 2025, August 8, 2025, August 14, 2025, August 20, 2025, August 21, 2025, August 27, 2025, August 28, 2025, August 29, 2025, August 31, 2025, September 1, 2025, September 4, 2025, and September 8, 2025, indicated a noted skin wound on R9's coccyx area (lower back/tailbone area). The notes indicated ongoing measurements, condition/changes in the wound, and changes in wound care orders as completed by various facility and hospice nurses.</p> <p>R9's Master Assessment dated August 28, 2025, on pages 13-14 in the section 7. labeled Other Medical needs; statement 4. read "indicate level of assistance for skin care needs. The nurse selected. Needs/receives skin condition monitoring during other scheduled services by unlicensed personnel." Additionally, statement 6. read "Are there any additional services that require a licensed nurse to assist? the nurse selected "A. No".</p> <p>R9's Master Assessments dated March 13, 2025, June 17, 2025, and August 28, 2025, were provided. In the section labeled Outside Provider: Home Health and Hospice included the question "Does the resident receive care from an outside agency?" The responses by the nurse for each</p>	01620			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>			
(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	<p>Continued From page 10</p> <p>assessment indicated "A. N/A; no outside agencies in place."</p> <p>The licensee failed to complete accurate information regarding R9's wound, wound progress, and wound management by nursing within the Master Assessment dated August 28, 2025. Furthermore, the licensee failed to ensure ongoing assessments accurately depicted R9's outside agency (hospice) support being provided since February 2025.</p> <p>On September 11, 2025, at 12:20 p.m., CNS-B stated the assessments flow with information from the previous assessment and nurses needed to slow down and review all parts of the assessment for accuracy with known changes since the previous assessments. The details outlined above were missed.</p> <p>R10 R10 was admitted to the facility on February 4, 2025, with diagnoses including dementia, hypertensive heart disease with heart failure, and type 2 diabetes with nephropathy (damage to kidneys associated with diabetes).</p> <p>R10's Service Agreement dated February 4, 2025, indicated R10 received services including medication management, compression wraps, blood sugar monitoring, insulin administration, and assistance with dressing, bathing, grooming, toileting, and safety checks.</p> <p>On September 9, 2025, at 8:03 a.m., the surveyor observed ULP-H check R10's blood sugar and administer his insulin via insulin pen injection.</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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	<p>Continued From page 11</p> <p>R10's progress note dated June 19, 2025, indicated R10 was involved in a resident-to-resident altercation at the dining room table. R10 yelled at another resident and then hit the other resident in the face.</p> <p>R10's IAPP dated June 20, 2025, included the following:</p> <ul style="list-style-type: none"><li>- Page 1. question 2. read "Does resident post a risk to abusing others verbally?" The response indicated, "Yes".</li><li>- Page 1. question 3. read "Does resident pose a risk to abusing others with threatening behavior?" The response indicated, "Yes".</li><li>- Page 2. question 4. read, "Does resident pose a risk to abusing others physically (hitting, kicking, punching, pushing, grabbing, etc. The response indicated "Yes".</li></ul> <p>The above listed risks included interventions to redirect and remove other residents in his area. He was to be placed at a specific spot at the dining room table to allow space between him and other residents.</p> <p>R10's Master Assessment dated August 6, 2025, in the section labeled "Vulnerabilities and Abuse Prevention" included the following questions and responses:</p> <ul style="list-style-type: none"><li>- 2. Does resident pose a risk to abusing others verbally? The response read, "No"</li><li>- 3. Does resident post a risk to abusing others with threatening behavior? The response read, "No"</li><li>- 4. Does resident pose a risk to abusing others physically (hitting, kicking, punching, pushing, grabbing)? The response read, "No"</li></ul> <p>The licensee failed to accurately depict R10's</p>	01620			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  COTTAGEWOOD SENIOR COMM		STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST 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  susceptibility to abusing others within R10's assessment following his altercation with another vulnerable resident.  On September 10, 2025, at 2:52 p.m., CNS-B stated the vulnerability information within R10's assessment needed to mirror the updated IAPP completed on June 20, 2025, following the resident-to-resident altercation; and R10's assessment was not updated properly.  The licensee's Initial and Ongoing Nursing Assessment policy dated October 27, 2021, indicated the RN would complete a face-to-face comprehensive assessment with a resident's change in condition as indicated. Furthermore, the policy indicated the assessment would include an assessment of the resident's areas of vulnerability and susceptibility to maltreatment and whether the resident poses a risk to other vulnerable adults.  No further information was provided.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration  When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  COTTAGEWOOD SENIOR COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST 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
01750	<p>Continued From page 13</p> <p>in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-H) completed insulin administration via a prefilled insulin pen according to manufacturer instructions for two of two residents with insulin (R10, R13).</p> <p>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).</p> <p>The findings include:</p> <p>R10 R10 was admitted to the facility on February 4, 2025, with diagnoses including dementia, hypertensive heart disease with heart failure, and type 2 diabetes with nephropathy (damage to kidneys associated with diabetes).</p> <p>R10's Service Agreement dated February 4, 2025, indicated R10 received services including medication management/administration.</p> <p>R10's signed prescriber's order dated August 25, 2025, indicated Lantus Solostar 100 units/milliliter (U/ml), inject 5 units under the skin</p>	01750			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	<p>Continued From page 14</p> <p>every morning.</p> <p>On September 9, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-H remove R10's Lantus insulin pen from the medication cart, referenced R10's medication administration record (MAR) on the computer, and dialed the insulin pen to 5 units as directed. ULP-H then gathered R10's blood sugar testing equipment and an alcohol wipe and found R10. ULP-H first checked R10's blood sugar and then attached the insulin pen needle to the pen (without wiping the rubber pen tip with alcohol and without priming the pen needle with 2 units of insulin), wiped the skin on R10's abdomen and injected the insulin into the skin holding the pen in place for about one second.</p> <p>On September 9, 2025, at 8:05 a.m., ULP-H stated she was not aware she needed to prime the insulin pen needle with each dose given and thought once the insulin pen was put into use it was "good to go" for each use.</p> <p>R13 R13 was admitted to the facility on October 18, 2021, with diagnoses including dementia, type 2 diabetes, and hypertension.</p> <p>R13's Service Plan dated June 29, 2025, indicated he received services including medication management/administration.</p> <p>R13's signed prescriber's orders dated September 2, 2025, indicated Lantus Solostar 100 U/ml, give 16 units subcutaneously (under the skin) daily.</p>	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	<p>Continued From page 15</p> <p>On September 9, 2025, at 8:10 a.m., the surveyor observed ULP-H to reference R13's MAR and pulled out R13's Lantus insulin pen, applied the pen needle (without wiping the rubber tip), dialed the pen to 2 units to prime the pen, then noted the pen had 9 units of insulin remaining and stated she needed to open another insulin pen to provide the total prescribed dosing of 16 units. ULP-H removed a new pen from the medication refrigerator, attached the pen needle and primed with 2 units of insulin and dialed the pen to 7 units. ULP-H then wrote the opened date on the pen. ULP-H gathered R13's blood sugar testing equipment and found R13. ULP-H first checked R13's blood sugar and then wiped an area on R13's abdomen for his insulin injections. ULP-H injected each insulin pen close to the same area holding the insulin pens for 1-2 seconds.</p> <p>On September 9, 2025, at 8:15 a.m., ULP-H stated she had probably been told but forgot she needed to wipe the insulin pen tips prior to placing a new needle and forgot to hold the insulin pen in place for the designated 5-10 seconds.</p> <p>The licensee failed to ensure the proper procedure was followed for a prefilled insulin pen by wiping the rubber tip of the pen, priming the pen needle once attached, and holding the insulin pen in place for 10 seconds to ensure proper infection control and proper insulin dosing was provided to residents.</p> <p>On September 9, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated she expected staff to follow the proper procedure for insulin pen administration by wiping the rubber tip of the</p>	01750			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	<p>Continued From page 16</p> <p>pen, priming the pen needle with 2 units of insulin and holding the insulin pen in place during administration to allow for proper dosing. She further stated some of the long-term staff had shortcuts or were in a hurry and would need to follow up with retraining of staff to ensure proper procedures were followed.</p> <p>Basaglar (Lantus Solostar) manufacturer's instructions dated November 2022, indicated to wipe the insulin pen rubber seal with an alcohol wipe prior to attaching a new needle, and indicated to prime the new needle with 2 units of insulin prior to dialing the dose of insulin to be given. With injection of the insulin, hold the dose knob in and slowly count to "5" before removing the needle.</p> <p>The licensee's undated, Insulin Pen Injection Skill, indicated to prepare the insulin pen, remove the pen cap and clean with alcohol swab, connect the needle to the pen, and prime the pen with 2 units of insulin or until insulin comes out of the needle. When injecting insulin, slowly push the knob of the pen all the way in to deliver the full dose, remember to hold the pen at the site for 5-10 seconds and then pull the needle out.</p> <p>The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 28, 2021, indicated unlicensed personnel that satisfy the training requirements, have been determined competent to follow the procedures and have been delegated the responsibility by the registered nurse (RN), may administer medications, orally, by suppository, through eye drops, through ear drops, by use of inhalant or nebulizer, gastric tube, insulin injection or topically by following the RN's written</p>	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 17  instructions for administering the medications to the client.  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=F	<b>144G.71 Subd. 8</b> Documentation of administration of medication  Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.  This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for three of six residents (R2, R5, R12).  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	01760			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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
01760	<p>Continued From page 18</p> <p>problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R2</p> <p>R2 was admitted to the facility on March 6, 2025, and was currently living in Cottage #2 of the assisted living with dementia care (ALFDC) campus. R2 had diagnoses including neurocognitive disorder with Lewy bodies dementia, delirium, and urinary retention with presence of suprapubic urinary catheter (a catheter placed through the abdomen into the bladder) and leukemia.</p> <p>R2's Service Agreement dated March 6, 2025, included the services of medication management/administration.</p> <p>R2's medication administration record (MAR) dated September 2025, indicated R2 received one oral medication for pain, one for nerve pain, three for constipation, one for sleep, one for agitation, one for low blood pressure, one for acid reflux, one for treatment of leukemia, one for prostate enlargement, one for electrolyte replacement, one steroid, one rectal medication for constipation, one topical patch for agitation, two topical medications for skin irritation, two for pain, and one normal saline flush for urinary catheter irrigation.</p> <p>R2's signed prescriber's orders dated September 6, 2025, indicated: -diclofenac 1% gel, apply 4 grams (gm) to hips/sciatic area four times daily as needed for pain.</p>	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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
01760	<p>Continued From page 19</p> <p><b>R5</b> R5 was admitted to the facility on September 4, 2024, and was currently living at Cottage #2 of the ALFDC campus. R5 had diagnoses including Alzheimer's dementia with agitation.</p> <p>R5's Service Agreement dated January 10, 2025, included the services of medication management/administration.</p> <p>R5's MAR dated September 2025, indicated R5 received one oral medication for Parkinson's disease related tremors, two for agitation, two for depression, one for sleep, one for dementia, two for constipation, three supplements, one rectal medication for constipation, one eye drop for dry eyes, and one topical pain medication,</p> <p>R5's signed prescriber's orders dated September 4, 2025, indicated: -diclofenac 1% gel, apply 2 gm twice daily and up to twice daily as needed for pain.</p> <p>On September 8, 2025, at 1:15 p.m., the surveyor and unlicensed personnel (ULP)-D reviewed the contents of Cottage #2's medication cart. The surveyor observed two tubes of resident (R2, R5) labeled diclofenac gel in the top drawer of the medication cart. The surveyor did not observe any diclofenac measuring tools. When asked about how the ULP were measuring the diclofenac for residents, ULP-D stated, "I just squirt some on my gloved finger and apply it to the area indicated on the medication administration record (MAR). I guess I don't know how much it is."</p> <p><b>R12</b></p>	01760			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  COTTAGEWOOD SENIOR COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST 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
01760	<p>Continued From page 20</p> <p>R12 was admitted to the facility on November 18, 2024, and was currently living at Cottage #6 of the ALFDC campus. R12 had diagnoses including neurocognitive disorder, Parkinson's disease with Lewy body dementia.</p> <p>R12's Service Agreement dated January 10, 2025, included the services of medication management/administration.</p> <p>R12's MAR dated September 2025, included one oral medication for pain, two for sleep, one for Parkinson's disease, one for prostate enlargement, one for constipation, one for agitation, one for depression, one blood thinner, one supplement/antacid, one topical patch for mood control, one topical (on the skin) medication for skin redness and three topical medications for pain.</p> <p>R12's signed prescriber's orders dated November 18, 2024, indicated: -diclofenac 1% gel, apply 4 gm to upper legs four times daily for pain.</p> <p>On September 9, 2025, at 8:40 a.m., the surveyor observed ULP-H set up and administer R12's diclofenac gel. ULP-H checked R12's MAR, squirted an unknown amount of diclofenac gel on her gloved fingers and apply to R12's bilateral upper legs. When asked about how much diclofenac was squirted on her gloved fingers, ULP-H stated, "I have no idea how much it was. I didn't know or don't remember being told about a measuring tool for the diclofenac."</p> <p>The licensee failed to ensure R2, R5, and R12's diclofenac was accurately measured for proper dosing.</p>	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  COTTAGEWOOD SENIOR COMM		STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST 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
01760	Continued From page 21  On September 9, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated the diclofenac should always be measured with the enclosed measuring tool. She further stated she would retrain staff and include a note in each resident's MAR to use the tool for proper dosing.  The licensee's Administration of Medication, Treatment and Therapy by unlicensed Personnel policy dated July 28, 2021, indicated medications, treatment and therapy always need to be administered according to the "6 Rights" including: a. Right person b. Right medication, treatment or therapy c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. Right chart/record to document that the medication, treatment and therapy was taken  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days.	01760			
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			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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
01890	<p>Continued From page 22</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label time sensitive medications with an opened date for three of three residents (R3, R4, R6).</p> <p>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).</p> <p>The findings include:</p> <p>On September 8, 2025, at 1:15 p.m., the surveyor and unlicensed personnel (ULP)-D reviewed the contents of Cottage 2's medication cart and the following were observed to lack an opened date: -R3- latanoprost eye drops, one opened bottle -R4-Refresh eye drops, one opened bottle ULP-D stated the eye drops usually had an opened date on the box housing the bottle; however, these bottles did not include the boxes nor an opened date on the bottle.</p> <p>On September 9, 2025, at 8:30 a.m., the surveyor and ULP-H reviewed the contents of Cottage 6's medication cart and the following were observed to lack an opened date: -R6-Refresh eye drops, one opened bottle</p> <p>On September 9, 2025, at 9:35 a.m., clinical nurse supervisor (CNS)-B stated open dates</p>	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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
01890	<p>Continued From page 23</p> <p>needed to be included on time sensitive medications, including eye drops.</p> <p>Latanoprost eye drop manufacturer's instructions dated August 2011, indicated once a bottle is opened for use, it may be stored at room temperature up to 77 degrees Fahrenheit for six weeks.</p> <p>Refresh eye drops manufacturer's instruction dated March 2024, indicated discard 90 days after opening.</p> <p>The licensee's Storage of Medications policy dated July 28, 2021, indicated until the medication is set up for immediate or later administration by a nurse, the medication must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications</p> <p>No further information provided</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01890			
01940 SS=D	<p><b>144G.72 Subd. 3 Individualized treatment or therapy managemen</b></p> <p>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</p>	01940			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	<p>Continued From page 24</p> <p>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:</p> <p>(1) a statement of the type of services that will be provided;</p> <p>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</p> <p>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</p> <p>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</p> <p>(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.</p> <p>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 provided for two of four residents (R2, R9) receiving treatments.</p> <p>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</p>	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	<p>Continued From page 25</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on September 8, 2025, at 11:00 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services to residents as prescribed.</p> <p>R2</p> <p>R2 was admitted to the facility on March 6, 2025, with diagnoses including neurocognitive disorder with Lewy bodies dementia, delirium, and urinary retention with presence of suprapubic urinary catheter (a catheter placed through the abdomen into the bladder).</p> <p>R2's Service Agreement dated March 6, 2025, included the services of assistance with bathing, grooming, dressing, medication management, behavior management and urinary catheter management (emptying catheter bag and catheter bag exchange).</p> <p>On September 8, 2025, at 12:10 p.m., the surveyor observed registered nurse (RN)-C flush R2's suprapubic urinary catheter with 60 milliliters (ml) of normal saline solution. RN-C stated the facility nurses were currently flushing R2's catheter four times daily to manage recent issues with bladder sediment plugging the catheter.</p> <p>R2's progress notes dated March 2025, to June 5, 2025, indicated the presence of an indwelling Foley catheter (catheter placed through R2's</p>	01940			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  20391	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  COTTAGEWOOD SENIOR COMM			STREET ADDRESS, CITY, STATE, ZIP CODE 4216 55TH ST NW ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	<p>Continued From page 26</p> <p>urethra). R2's progress note dated June 5, 2025, indicated the initiation of catheter flushes with 60 milliliters (ml) normal saline twice daily by the licensee's nurses. R2's progress notes between June and July 2025, included several entries by the licensee's nurses indicating plugging issues with R2's catheter. R2's progress note dated July 7, 2025, indicated a suprapubic catheter had been placed. R2's progress notes dated July through September 2025, included multiple entries with varying suprapubic catheter flushing frequencies (twice daily to four times daily) with varying volumes of normal saline flushes (60-240 ml) by the licensee's nurses.</p> <p>R2's record included an After Visit Summary (AVS) dated September 6, 2025, indicating a larger sized suprapubic catheter had been placed, and included instructions to flush the catheter four times daily or more as needed. The order did not include a quantity of normal saline.</p> <p>R2's medication administration record (MAR) dated September 2025, indicated flush catheter with 60 ml normal saline four times daily.</p> <p>On September 11, 2025, at 12:15 p.m., CNS-B stated R2 had multiple incidents of catheter issues over the past several months which initiated the need for the licensee's nurses to flush the catheter to maintain patency. CNS-B further stated R2's Service Agreement was not updated to include the catheter flushes once they started several months ago.</p> <p>The licensee indicated the tasks of catheter bag</p>	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	<p>Continued From page 27</p> <p>emptying and urinary bag exchanges (from small leg bag to full overnight bag) as delegated tasks for the unlicensed personnel in R2's Service Agreement; however, the licensee failed to include in his Service Agreement, R2's treatment of suprapubic catheter flushes as done by the licensee's nurses.</p> <p>R9 R9 was admitted to the facility on May 19, 2022, with diagnoses including major neurocognitive disorder without behavioral disturbance, type 2 diabetes with neuropathy (nerve pain), and history of stroke.</p> <p>R9's Service Agreement dated June 3, 2025, included the services of hospice, two-person assistance with dressing, bathing, toileting, and transfers with mechanical lift, assistance with staff escort, medication management, and assistance with meals. R9's Service Agreement lacked the services of urinary catheter management and wound care.</p> <p>On September 9, 2025, at 7:30 a.m., registered nurse (RN)-G was observed to provide wound care to R9 sacral area (lower back/tail bone area). RN-G placed an acetic acid-soaked dressing over R9's sacral area and stated the treatment plan was to keep that dressing in place for two hours, then remove and leave open to air within R9's incontinence brief. RN-G stated this process was completed twice daily by the facility nurse or trained unlicensed personnel. Furthermore, the surveyor observed R9 to have an indwelling urinary catheter in place. RN-G stated R9 had the indwelling catheter placed by hospice and was used to keep her sacral wound dry from R9's urinary incontinence. RN-G stated</p>	01940			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	<p>Continued From page 28</p> <p>the facility staff (nurses and unlicensed personnel) managed the catheter (catheter site care and emptying the bag).</p> <p>R9's prescriber's order dated September 8, 2025, indicated wound care order initiated on August 21, 2025, which read: Coccyx Wound care orders: -Moisten 4 x 4 gauze with 0.25% acetic acid solution and place in contact with the reddened area of the coccyx for two hours twice per day. -Wound care to be done by Hospice nurse, facility nurse, or facility staff per facility nurse guidance.</p> <p>R9's prescriber's order dated September 8, 2025, indicated Foley catheter order initiated on August 29, 2025, and read: -Hospice nurse to perform catheter insertion, maintenance, and removal. Perform indwelling catheter change as needed to maintain patency using 14 French cath [catheter] with 10 [ml] balloon. Irrigate catheter with 60 milliliters normal saline as needed to maintain patency.</p> <p>R9's MAR dated September 2025, included: -for wound care-Moisten 4 X 4 gauze with .25% acetic acid solution-place in contact with reddened area of coccyx for 2 hours - twice per day. Wound care to be done by Hospice nurse, Facility nurse, or facility staff per facility nurse guidance. -Empty Catheter Collection Bag AM Please empty the catheter and record the amount obtained. The MAR indicated this was being completed twice daily -Irrigate Foley Catheter Irrigate catheter with 60 ml Normal Saline as needed to maintain patency.</p>	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01940	<p>Continued From page 29</p> <p>On September 11, 2025, at 12:20 p.m. CNS-B stated R9's catheter and wound care management was an oversight by the licensee's nurses and were not included in R9's Service Agreement.</p> <p>The licensee failed to include R9's treatments of urinary catheter management and wound care in her Service Plan.</p> <p>The licensee's Development of the Individualized Treatment and Therapy Management Plan policy dated October 27, 2021, indicated 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.</p> <p>No further information provided</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01940			
01970 SS=D	<p>144G.72 Subd. 6 Treatment and therapy orders</p> <p>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.</p> <p>This MN Requirement is not met as evidenced by:</p>	01970			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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
01970	<p>Continued From page 30</p> <p>Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of four residents (R7, R10) receiving treatments.</p> <p>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).</p> <p>The findings include:</p> <p>R7 R7 was admitted to the facility on October 21, 2021, with diagnoses including dementia, type 2 diabetes, and heart failure.</p> <p>R7's Service Agreement dated February 10, 2025, included the services of assistance with bathing, dressing, grooming, toileting, blood sugar monitoring, compression stockings, medication management and behavior management.</p> <p>On September 8, 2025, at 3:56 p.m., the surveyor observed unlicensed personnel (ULP)-E check R7's blood sugar. R7 was observed wearing compression stockings that ULP-E stated were put on earlier that morning.</p> <p>R7's Service Check Off List dated September 2025, indicated R7 required assistance by one staff to don her compression stockings in the</p>	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>			
(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
01970	<p>Continued From page 31</p> <p>morning and assistance of one staff to remove them in the evening.</p> <p>On September 11, 2025, at 12:12 p.m., clinical nurse supervisor (CNS)-B stated the licensee's nurses were looking for an updated order for R7's compression stockings.</p> <p>On September 11, 2025, at 2:36 p.m., the surveyor received an updated, signed, prescriber's order for R7's compression stockings dated September 11, 2025, (during survey) indicating "Please order 2 [two] pairs of compression stockings. 15-20 mmHg [millimeters/mercury-measurement of compression pressure]. Put on in the morning upon waking and take off at bedtime. Nursing, please measure patient and include with order. Amendment Electronically Signed by [prescriber name] 09/11/2025 02: 11:27 PM."</p> <p>The licensee failed to ensure a current signed order for R7's compression stockings was maintained.</p> <p>R10 R10 was admitted to the facility on February 4, 2025, with diagnoses including dementia, hypertensive heart disease with heart failure, and type 2 diabetes with nephropathy (damage to kidneys associated with diabetes).</p> <p>R10's Service Agreement dated February 4, 2025, indicated R10 received services including medication management, compression wraps, blood sugar monitoring, insulin administration, and assistance with dressing, bathing, grooming, toileting, and safety checks.</p>	01970			



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>		
(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
01970	<p>Continued From page 32</p> <p>On September 9, 2025, at 8:03 a.m., the surveyor observed unlicensed personnel (ULP)-H check R10's blood sugar and administer his insulin via insulin pen injection.</p> <p>R10's Medication Administration Record (MAR) dated September 2025, indicated "Blood Glucose [sugar] Checks, Check blood Glucose [sugar] twice a day and record. Patient has a continuous Glucose reader on his phone- Libre Brand. Make sure phone is charging each night. Notify nurse on duty if less than 80 or greater than 250."</p> <p>On September 11, 2025, at 11:45 a.m., CNS-B stated the licensee's nurses were looking for an updated order for R10's blood sugar checks/monitoring.</p> <p>On September 11, 2025, at 2:36 p.m., the surveyor received an updated order dated September 11, 2025, (during survey) indicating blood sugar checks twice daily.</p> <p>The licensee failed to ensure a current signed order for R10's blood sugar checks was maintained.</p> <p>On September 11, 2025, at 2:45 p.m. CNS-B stated the R7's order for compression stockings and R10's order for blood sugar monitoring were not found in the residents' charts and were obtained by the resident's providers during the time of survey.</p> <p>The licensee's Renewal of Medication, Treatment, or Therapy Prescriptions and Orders policy dated August 23, 2021, indicated a medication prescription or a treatment or therapy order must current and must be renewed at least</p>	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20391</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/11/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COTTAGEWOOD SENIOR COMM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4216 55TH ST NW ROCHESTER, MN 55901</b>			
(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
01970	Continued From page 33  every twelve (12) months  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days	01970			





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

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
COTTAGEWOOD SENIOR COMMUNITIES 4220 55TH STREET NW Rochester, MN 55901 Olmsted County Parcel:  Phone: 507-529-3110 ktalamantes@gentletouchhealth.com	License: HFID 20391 Kelly Talamantes Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F1038251070 Inspection Type: Full - Single Date: 9/9/2025 Time: 10:02:30 AM Duration: 60 minutes Announced Inspection: No <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery:</u>

No orders were issued for this inspection report.

**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 F1038251070 from 9/9/2025**

Pat Patrick  
Dining Service Coordinator

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

Page: 1

### Establishment Info

COTTAGEWOOD SENIOR COMMUNITIES  
Rochester  
County/Group: Olmsted County

### Inspection Info

Report Number: F1038251070  
Inspection Type: Full  
Date: 9/9/2025  
Time: 10:02:30 AM

**Food Temperature:** **Product/Item/Unit:** spaghetti; **Temperature Process:** Cooking

**Location:** Oven at 188 Degrees F.

Comment:

*Violation Issued?: No*

**Food Temperature:** **Product/Item/Unit:** Butter; **Temperature Process:** Cold-Holding

**Location:** Walk-in Cooler at 40 Degrees F.

Comment:

*Violation Issued?: No*

**Food Temperature:** **Product/Item/Unit:** Ice Cream; **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

Page: 1

### Establishment Info

COTTAGEWOOD SENIOR COMMUNITIES  
Rochester  
County/Group: Olmsted County

### Inspection Info

Report Number: F1038251070  
Inspection Type: Full  
Date: 9/9/2025  
Time: 10:02:30 AM

**Sanitizing Chemical:** Product: Chlorine; **Sanitizing Process:** Dish Machine

**Location:** Dishwashing Area **Equal To** 100 PPM

Comment:

*Violation Issued?: No*

**Sanitizing Chemical:** Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser


**Location:** Dishwashing Area **Equal To** 200 PPM

Comment:

*Violation Issued?: No*



Food Establishment Inspection Report

 <div>Rochester District Office Minnesota Department of Health 3425 40th Avenue NW, Suite 115 Rochester, MN 55901</div>	No. of Risk Factor/Intervention/Violations		0	Date: 9/9/2025
	No. of Repeat Risk Factor/Intervention/Violations			Time: 10:02:30 AM
	Score (optional)			Dur: 60 min
Establishment: COTTAGEWOOD SENIOR COMMUNITIES	Address: 4220 55TH STREET NW	City/State: Rochester, MN	Zip: 55901	Phone: 507-529-3110
License/Permit #: HFID 20391	Permit Holder: Kelly Talamantes	Purpose of Inspection: Full	Est. Type:	Risk Category:

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	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	IN	Proper cooking time & temperatures		
2	IN	Certified Food Protection Manager			19	N/O	Proper reheating procedures for hot holding		
Employee Health					20	N/O	Proper cooling time and temperature		
3	IN	knowledge, responsibilities, and reporting			21	N/O	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	IN	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	IN	Proper date marking & disposition		
Good Hygienic Practices					24	N/O	Time as public health control;procedures & record		
6	N/O	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	N/O	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	N/O	Hands clean and properly washed			26	IN	Pasteurized foods used; prohibited foods not offered		
9	N/O	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	IN	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	IN	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			<div>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</div>				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	IN	Food separated and protected							
16	IN	Food-contact surfaces; cleaned & sanitized							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							

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 <b>not</b> in compliance    Mark "X" in appropriate box for COS and/or R    COS=corrected on-site during inspection    R=repeat violation									
			COS	R				COS	R
Safe Food and Water					Proper Use of Utensils				
30	IN	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/O	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48		Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
					58		Compliance with licensing and plan review		

Inspector (signature)	Follow-up: No      Follow-up Date:
-----------------------	------------------------------------