Electronically Delivered

March 20, 2026

Licensee
The Meadows
1761 Eagle View Circle
Albert Lea, MN 56007

RE: Project Number(s) SL32452016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 27, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32452	A. BUILDING: _____ B. WING _____	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS	1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32452016-0 On February 23, 2026, through February 27, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 28 residents; 28 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February, 24, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 72 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control during medication administration for one of two unlicensed personnel (ULP-C). 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).	0 510		

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0 510	Continued From page 4 The findings include: On February 24, 2026, at 9:03 a.m., the surveyor observed ULP-C prepare and administer medications to R1 in R1's room. ULP-C was popping medications from the medication card into her gloved hand and placing them into the medication cup for administration. During the process, ULP-C dropped a pill onto the floor. ULP-C reached down and picked up the pill from the floor and placed it into the medication cup. ULP-C then administered the medications to R1. Immediately following the observation, ULP-C stated she should have asked the resident whether she wanted the pill that had fallen on the floor or provided a new pill from the medication card and notified the nurse that the medication had been dropped. On February 25, 2026, at 1:48 p.m., clinical nurse supervisor (CNS)-B stated if staff drop a pill on the floor, they should put the pill in an envelope and give it to the nurse for disposal. The ULP should then take a new pill from the medication card and use that to administer to the resident. CNS-B indicated a medication that has been on the floor would be an infection control concern. The licensee's undated, Loss or Spillage of Medications, Including Controlled Medications policy, indicated the following: 2. A medication that is dropped or spilled will be routinely disposed of unless the resident refuses. The licensee's undated, Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy noted infection control precautions must be followed when administering medications.	0 510		

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0 510	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01290 SS=D	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 a background study was submitted and received in affiliation with the assisted living license health facility identification number (HFID) for one of three employees (unlicensed personnel (ULP)-D). 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	01290		

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01290	Continued From page 6 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D began providing assisted living services on September 16, 2025. ULP-D's employee record contained a Background Study Clearance form dated September 19, 2025, for HFID 31639 (a separate location operated by the licensee's owner). ULP-D's employee record lacked evidence the licensee affiliated a background study for their current assisted living license HFID 32452. On February 25, 2026, at 11:20 a.m., licensed assisted living director (LALD)-A stated ULP-D's background study had not been affiliated with the assisted living facility license HFID. LALD-A indicated ULP-D had a background study clearance letter from a "sister" facility. The licensee's undated, Background Checks policy noted all employees with direct resident contact would undergo a background study through Department of Human Services (DHS). No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 7 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was developed to include all services the licensee provided for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01640		

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01640	Continued From page 8 The findings include: R5 was admitted on November 18, 2024, with diagnoses that included edema (swelling in the extremities), sleep apnea (repeated interruptions in breathing during sleep), and dementia. On February 24, 2026, at 8:39 a.m., the surveyor observed unlicensed personnel (ULP)-C apply R5's Juxtalite wraps (velcro compression stockings) to bilateral lower extremities. R5's task documentation dated October 24, 2025, through February 24, 2026, included documentation of staff assisting R5 to apply continuous positive airway pressure (CPAP) at bedtime (for sleep apnea), and Juxtalite wraps on in AM and off at bedtime. R5's Weight Summary dated February 2, 2026, through February 24, 2026, included documentation of staff obtaining daily weights for R5. R5's prescriber orders dated December 16, 2025, included daily weights. Notify provider if weight gain greater than 3 pounds (lbs) one day or 5 lbs in one week. R5's prescriber orders dated January 5, 2026, included Juxtalite wraps to bilateral lower extremities- ankle to knee at 20-30 millimeter of mercury (mmHG). Apply in AM and remove at bedtime. R5 lacked prescriber orders for CPAP. R5's service plan dated November 18, 2024, indicated R5 received services to include bathing assistance and medication management. The service plan lacked the following treatments: CPAP every night, Juxtalite wraps to bilateral lower extremities daily, and daily weights. On February 25, 2026, at 1:07 p.m., clinical nurse	01640		

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01640	Continued From page 9 supervisor (CNS)-B stated R5's service plan lacked the treatment of CPAP, Juxtalite wraps, and daily weights. CNS-B stated a service plan should have been revised to include the above identified services. The licensee's undated Contents of Service Plans policy noted: 1. A finalized service plan will be completed no later than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriber	01760		

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01760	Continued From page 10 orders were transcribed for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 7, 2025, with diagnoses that included dementia and osteoarthritis (joint pain and stiffness). R1's service plan dated November 5, 2025, indicated R1 received services to include medication administration. R1's prescriber orders dated February 16, 2026, included orders for: - diclofenac 1% (topical pain gel); apply 4 grams (gm) topically to bilateral knees three times per day and once daily as needed. R1's February 2026, medication administration record (MAR) included diclofenac 1% gel apply to bilateral knees topically three times a day. The MAR did not include the amount of diclofenac 1% gel to administer. On February 24, 2026, at 9:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administer diclofenac 1% gel to R1. The diclofenac 1% gel label identified to apply 4 grams to R1's bilateral knees. ULP-C applied	01760		

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01760	Continued From page 11 gloves, placed a dime size amount of gel to her gloved hand, and applied to R1's left knee. ULP-C did not measure the amount of diclofenac gel. ULP-C then removed her gloves, sanitized, and documented the administration. Following the administration of the medication, the surveyor asked ULP-C how much diclofenac 1% gel she was suppose to apply. ULP-C stated it was not identified on the MAR but indicated a dime size was enough to cover R1's left knee. ULP-C further stated R1 only wanted the diclofenac 1% gel applied to her left knee, not both knees as indicated on the MAR. On February 25, 2026, at 1:53 p.m., CNS-B stated R1's order for diclofenac 1% gel was lacking the dosage on the MAR and had not been transcribed as ordered by the prescriber. 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription	01890		

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01890	Continued From page 12 label for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 24, 2026, at 9:03 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1's medications were stored within a locked medication cupboard in R1's room. ULP-C removed R1's Humulin N (intermediate-acting) insulin from the cupboard. The Humulin N insulin lacked the original prescription label with information regarding the directions for use, medication name, medication dosage, and the pharmacy in which it had been dispensed. When interviewed at this time, ULP-C stated there was not a label on the insulin pen, but she would follow the directions on the computer for administration. On February 24, 2026, at 9:10 a.m., clinical nurse supervisor (CNS)-B stated all medication should have original prescription labels and indicated someone may have thrown away the insulin bag bearing the label. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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	32452	A. BUILDING: _____ B. WING _____	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS	1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

(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	Continued From page 13 days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01940		

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THE MEADOWS	1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

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01940	Continued From page 14 review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 23, 2026, at 11:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to the residents at the facility. R5 was admitted on November 18, 2024, with diagnoses that included edema (swelling in the extremities), sleep apnea (repeated interruptions in breathing during sleep), and dementia. On February 24, 2026, at 8:39 a.m., the surveyor observed unlicensed personnel (ULP)-C apply R5's Juxtalite wraps (velcro compression stockings) to bilateral lower extremities. On February 25, 2026, at 12:43 p.m., R5 stated staff apply his continuous positive airway pressure (CPAP) at night (for sleep apnea). R5's service plan dated November 18, 2024, indicated R5 received services to include bathing assistance and medication management. The	01940		

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01940	Continued From page 15 service plan lacked the treatment of CPAP every night and Juxtalite wraps to bilateral lower extremities daily. R5's prescriber orders dated January 5, 2026, included Juxtalite wraps to bilateral lower extremities- ankle to knee at 20-30 millimeter of mercury (mmHG). Apply in AM and remove at bedtime. R5 lacked prescriber orders for CPAP. R5's task documentation dated October 24, 2025, through February 24, 2026, included documentation of staff assisting R5 to apply CPAP at bedtime and Juxtalite wraps on in AM and off at bedtime. R5's record failed to include the following content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. - 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. On February 25, 2026, at 1:07 p.m., clinical nurse supervisor (CNS)-B stated R5's record lacked a treatment management plan to include all the required content as noted above. The licensee's undated, Individualized Medication, Treatment & Therapy Management Plan policy noted the registered nurse (RN) would develop a treatment plan that would include: d. procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatment services. e. resident-specific requirements relating to	01940		

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THE MEADOWS	1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

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01940	Continued From page 16 documentation of treatment received, verification that all treatment was administered as prescribed, and monitoring of treatment and to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded treatment orders were maintained for one of two residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at 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).	01970		

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THE MEADOWS	1761 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007

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01970	Continued From page 17 The findings include: During the entrance conference on February 23, 2026, at 11:12 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to the residents at the facility. On February 25, 2026, at 12:43 p.m., R5 stated staff apply his continuous positive airway pressure (CPAP) at night (for sleep apnea). R5 was admitted on November 18, 2024, with diagnoses that included sleep apnea (repeated interruptions in breathing during sleep). R5's service plan dated November 18, 2024, indicated R5 received services to include bathing assistance and medication management. The service plan lacked the treatment of CPAP every night. R5 lacked prescriber orders for CPAP. R5's task documentation dated October 23, 2025, through February 24, 2026, included documentation of staff assisting R5 to apply CPAP at bedtime. On February 25, 2025, at 1:07 p.m., CNS-B stated R5's record lacked prescriber orders for CPAP. CNS-B further indicated orders were required for CPAP. The licensee's undated, Documentation of Medication, Treatment and Therapy Management Services policy indicated the nurse would document actions to request and obtain needed prescriptions.	01970		

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01970	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for one of one resident (R4) with a bed rail. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4's diagnoses included hypertension (high blood pressure), transient cerebral ischemic attack (TIA) ("mini stroke"), and history of falling.	02310		

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02310	Continued From page 19 On February 24, 2026, at 12:14 p.m., R4's room was observed during conversation with R4. R4 had a hospital bed with both upper rails in place and raised. R4 indicated she used the rail to help herself with bed mobility. R4's Service Plan dated September 19, 2025, indicated R4 received services including assistance with bathing and medication administration. R4's Bed Rail Assessment V2 dated January 12, 2026, indicated R4 utilized a hospital bed with side rails to enable and promote independence. It also indicated R4/family had been educated on the risks and benefits of using the side rails; however, the assessment lacked measurements of the side rails zones one through four. On February 25, 2026, at 1:41 p.m., clinical nurse supervisor (CNS)-B stated she had not measured R4's side rails and indicated she had not done measurements for any residents who utilized a hospital bed with side rails. CNS-B indicated she was not aware of the requirement. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently	02310		

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02310	Continued From page 20 Asked Questions (FAQs) identified for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's undated, Devices and Device Assessment policy indicated for hospital beds: Device will be installed per FDA guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		
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 medications were administered according to policy and accepted standards of practice by one of two employees (unlicensed personnel (ULP)-C) and failed to ensure one of two employees (ULP-C) administered medications as prescribed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02320		

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02320	Continued From page 21 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on November 7, 2025, with diagnoses that included dementia and osteoarthritis (joint pain and stiffness). R1's service plan dated November 5, 2025, indicated R1 received services to include medication administration. R1's prescriber orders dated February 16, 2026, included orders for: - diclofenac 1% (topical pain gel); apply 4 grams (gm) topically to bilateral knees three times per day and once daily as needed. R1's February 2026, medication administration record (MAR) included diclofenac 1% gel apply to bilateral knees topically three times a day. The MAR did not include the amount of diclofenac 1% gel to administer. On February 24, 2026, at 9:03 a.m., the surveyor observed ULP-C administer diclofenac 1% gel to R1. The diclofenac 1% gel label identified to apply 4 grams to R1's bilateral knees. ULP-C applied gloves, placed a dime size amount of gel to her gloved hand, and applied to R1's left knee. ULP-C did not measure the amount of diclofenac gel. ULP-C then removed her gloves, sanitized, and documented the administration. Following the application of the gel, the surveyor asked ULP-C	02320		

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02320	Continued From page 22 how much diclofenac 1% gel she was supposed to apply. ULP-C stated it was not identified on the MAR but indicated a dime size was enough to cover R1's left knee. ULP-C further stated R1 only wanted the diclofenac 1% gel applied to her left knee, not both knees as indicated on the MAR. On February 25, 2026, at 1:53 p.m., clinical nurse supervisor (CNS)-B stated R1's order for diclofenac 1% gel was lacking the dosage on the MAR and had not been transcribed as ordered. In addition, CNS-B stated staff were taught and instructed to use a dosing card measuring device that identifies grams for an accurate measurement of the medication. CNS-B stated staff should have followed the orders as reflected on MAR and medication label but should have questioned why there was no dose identified. CNS-B further stated she would expect staff to notify her if the resident did not want it applied to locations identified on MAR or label. The diclofenac sodium instructions for use dated revised May 2016, identified to use the dosing card to correctly measure each dose. The licensee's undated, Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy included: 2. Medications need to be administered according to the "6 Rights" e. Right dose (how many milligrams, drops, etc.) No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

The Meadows
1761 Eagle View Circle
Albert Lea, MN 56007
Freeborn County
Parcel:

Phone:
bmboettcher@stjohnsofalbertlea.org

License Info

License: HFID 32452

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8044261062
Inspection Type: Full - Single
Date: 2/24/2026 Time: 8:33:02 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: The following foods were dated over seven days old:

Sliced turkey in assisted living upright cooler; 2/14.
Sliced ham in assisted living upright cooler; 2/9.

Foods discarded while on site.
Comply By: 2/24/2026 Originally Issued On: 2/24/2026

! **New Order: 5-200B Plumbing: cross connections**
5-203.14A *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.
COMMENT: No air gap with floor drain for water softener discharge line.
Comply By: 2/24/2026 Originally Issued On: 2/24/2026

New Order: 7-100 Toxic Labeling
7-102.11 *Priority Level: Priority 2 CFP#: 28*
MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.
COMMENT: Staff accidentally filled spray bottle labeled as sanitizer with window cleaner.

Bottle emptied on site and filled with quaternary ammonium sanitizer.
Comply By: 2/24/2026 Originally Issued On: 2/24/2026

Food & Beverage General Comment

HRD inspection conducted with Nursing Evalulator, Susan Kalis. Inspection report reviewed on site with Director of Culinary Services, Carrie Seath.

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 F8044261062 from 2/24/2026

Carrie Seath
Director of Culinary Services

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