Electronically Delivered

January 15, 2026

Licensee
Buhl Carefree Living by Oxford Living
500 East Monroe Drive
Buhl, MN 55713

RE: Project Number(s) SL26432017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 17, 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 . . ."

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26432	A. BUILDING: _____ B. WING _____	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHL CAREFREE LIVING BY OXFORD LIVING	500 EAST MONROE DRIVE BUHL, MN 55713

(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: SL26432017-0 On December 15, 2025, through December 17, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider and the following correction orders are issued. At the time of the survey, there were 18 residents; 18 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag."The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 1 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 16, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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

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0 810	Continued From page 3 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 16, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated	0 950		

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0 950	Continued From page 4 Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all resident assisted living contracts included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all residents who received services at the assisted living facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 15, 2025, at 12:42 p.m., assisted living director in residency (ALDIR)-J stated the licensee was familiar with current minimum assisted living requirements.	0 950		

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0 950	Continued From page 5 On page 12 of the licensee's undated Master Community Residency Agreement (assisted living contract) contained the following notice: Responsible Person: Residents are encouraged, but not required, to designate a family member or friend to sign this Agreement as the Resident's Responsible Person [sic]. Any person who signs as the Responsible Person may serve in one or more of the roles listed below. Resident to initial box, if declining to name a representative. Responsible party, legal representative, financially responsible person, and financial guarantor were options for the responsible person to elect. On December 16, 2025, at 12:08 p.m., administrative assistant (AA)-L stated the licensee's designated representative section was not word for word as required for the designated representative verbatim notice. AA-L further stated all residents received the same designated representative verbatim notice. On December 17, 2025, at 9:13 a.m., regional registered nurse (RRN)-I stated the licensee did not provide residents with the required designated representative verbatim notice, however, the licensee was in the process of revising the contract to include the required language. The licensee's Resident Contract Requirements policy dated January 16, 2023, indicated before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR	0 950		

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0 950	Continued From page 6 CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement	01060		

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01060	Continued From page 7 that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01060		

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01060	Continued From page 8 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 December 15, 2025, at 12:42 p.m., assisted living director in residency (ALDIR)-J stated the licensee was familiar with current minimum assisted living requirements. R5's diagnoses included chronic obstructive pulmonary disease (COPD- difficult breathing), diabetes, and hypertension (HTN- high blood pressure). R5's Service Plan dated November 7, 2025, indicated R5's services included medication administration, assistance with CPAP (continuous positive airway pressure used to keep airway open while sleeping), blood glucose checks, compression stockings (TEDS- used to decrease swelling in the legs), assistance with bathing, and light housekeeping. On December 16, 2025, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R5's scheduled morning medications. R5's Progress Notes indicated the following: -September 17, 2025, at 12:33 p.m., R5 was transported at 1130 (11:30 a.m.) and sent to the (facility name) emergency room; -September 18, 2025, at 12:33 p.m., R5 was possible for discharge tomorrow (September 19, 2025); and -September 22, 2025, at 5:25 p.m., R5 was discharged from the hospital and returned to the	01060		

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01060	Continued From page 9 assisted living facility. R5's AL (assisted living)- Uniform Assessment Tool dated September 22, 2025, indicated R5 was admitted to the emergency department on September 17, 2025, and was discharged from the hospital on September 22, 2025. R5's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R5's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On December 17, 2025, at 9:28 a.m., licensed practical nurse (LPN)-A stated the licensee had kept emergency relocation notices in a binder for residents. On December 17, 2025, at 10:16 a.m., LPN-A stated LPN-A was unable to locate R5's emergency relocation for September, however, the registered nurse (RN) or LPN-A had always provided emergency relocation paperwork for	01060		

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01060	Continued From page 10 hospitalizations and must have misplaced R5's emergency relocation for September 2025. The licensee's 1.23 Emergency Relocation policy dated January 16, 2023, indicated in the event of an emergency relocation, (licensee name) will provide a written notice to the resident, legal representative, designated representative, resident's case manager, if applicable, and the OOLTC (if the resident has not returned to the facility within four days) that contains, at a minimum: -The reason for the relocation; -The name and contact information for the location to which the resident has been relocated and any new service provider; -Contact information for the OOLTC and Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD); -If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse	01730		

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01730	Continued From page 11 must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.	01730		

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01730	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 15, 2025, at 12:46 p.m., licensed practical nurse (LPN)-A stated the licensee provided medication management to residents at the facility. R4's diagnoses included diabetes, hypertension (HTN- high blood pressure), and major depressive disorder. R4's Service Plan dated November 7, 2025, indicated R4's services included medication administration. R4's prescriber orders dated December 4, 2025, included two pain relievers, two antihypertensives, one allergy reliever, one for congestion, one antianxiety, three for diabetes, and two antidepressants.	01730		

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01730	Continued From page 13 On December 16, 2025, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-C compare R4's prescription labels to R4's electronic medical administration record (EMAR) and placed R4's oral medications into a plastic cup. ULP-C entered R4's room, administered R4's insulin, and left R4's oral medications on R4's table. ULP-C stated R4 had an order to leave R4's oral medications in R4's room to self-administer. R4's AL (assisted living)- Medication Management Plan dated December 30, 2024, indicated R4 was partially able to self-administer medications. Provider wrote an order that resident is able to administer some medications independently when set up by staff. In addition, provider wrote order for resident to keep ammonium and albuterol in room, ok to store in room and self admin (administer) topical agents as indicated in EMAR [sic]. R4's AL (assisted living) Uniform Assessment Tool dated October 22, 2025, indicated R4 is deemed able to partially safely self-administer medications. R4 stored topical medications in room. R4 was able to self-administer inhaler. R4's individualized medication management plan was not current to reflect R4 was assessed by the RN to complete self- administration of oral medications. On December 17, 2025, at 9:25 a.m., LPN-A stated R4 had a signed prescriber order, which indicated R4 was able to self-administer oral medications after the ULP placed the medications into the plastic cup. Regional registered nurse (RRN)-I stated R4's individualized medication	01730		

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01730	Continued From page 14 management plan was not updated with documentation to reflect self-administration of oral medications. The licensee's 2.00 Medication Management Services policy dated January 16, 2023, indicated the licensee will develop and maintain a current individualized medication management record for reach resident based on the resident's assessment, which included documentation of specific resident instructions relating to the administration of medications. In addition, the medication management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	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 in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01750		

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01750	Continued From page 15 review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for medications for one of two residents (R5) whose medication administration was delegated to unlicensed personnel (ULP). 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 December 15, 2025, at 12:46 p.m., licensed practical nurse (LPN)-A stated the licensee provided medication management to residents at the facility. R5's diagnoses included chronic obstructive pulmonary disease (COPD- difficult breathing), diabetes, and hypertension (HTN- high blood pressure). R5's Service Plan dated November 7, 2025, indicated R5's services included medication administration. R5's prescriber orders dated November 26, 2025, included the following orders: -diclofenac sodium 1% gel apply 4 (four) grams (g) topically to affected area four times per day; and -acetaminophen 500 milligrams (mg) take 1-2 (one to two) tablets by mouth every 8 (eight)	01750		

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01750	Continued From page 16 hours as needed for pain, be mindful of scheduled administration times. R5's Medication Administration Record (MAR) dated November 2025, and December 2025, respectively, indicated the following: -diclofenac 1% gel apply 4 g topically to affected area four times per day; and -acetaminophen 500 mg take 1-2 (one to two) tablets by mouth every 8 (eight) hours as needed for pain, be mindful of scheduled administration times. On December 16, 2025, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-F apply approximately a pea size amount of diclofenac sodium 1% gel to both of R5's shoulders. ULP-F stated R5 wanted ULPs to apply diclofenac sodium 1% gel to each of R5's shoulders for each administration of diclofenac sodium 1% gel. R5's record lacked resident specific instructions for the administration of where to apply diclofenac sodium 1% gel and specific instructions on when to administer one tablet or two tablets of acetaminophen 500 mg. On December 17, 2025, at 9:29 a.m., regional registered nurse (RRN)-I stated R5's record should have included specific instructions for where to apply diclofenac sodium 1% gel. RRN-I further stated the licensee needed to clarify R5's acetaminophen order for when to administer one tablet and when to administer two tablets. RRN-I stated resident medication administration records were supposed to include written specific instructions written by the registered nurse (RN). The licensee's 2.00 Medication Management	01750		

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01750	Continued From page 17 Services policy dated January 16, 2023, indicated the assisted living facility must ensure that the RN has specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for one of five residents (R5) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01760		

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01760	Continued From page 18 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 December 15, 2025, at 12:46 p.m., licensed practical nurse (LPN)-A stated the licensee provided medication management to residents at the facility. R5's diagnoses included chronic obstructive pulmonary disease (COPD- difficult breathing), diabetes, and hypertension (HTN- high blood pressure). R5's Service Plan dated November 7, 2025, indicated R5's services included medication administration. R5's prescriber orders dated November 26, 2025, included an order for diclofenac sodium 1% gel apply 4 (four) grams (g) topically to affected area four times per day. R5's Medication Administration Record (MAR) dated November 2025, and December 2025, respectively, indicated diclofenac 1% gel apply 4 g topically to affected area four times per day. On December 16, 2025, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-F apply approximately a pea size amount of diclofenac sodium 1% gel to both of R5's shoulders.	01760		

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01760	Continued From page 19 On December 16, 2025, at 11:39 a.m., ULP-F stated ULP-F applied approximately a pea size to penny size amount of diclofenac sodium 1% gel to each of R5's shoulders. ULP-F further stated ULP-F was told at a sister location to use a dosing card for measuring diclofenac sodium 1% gel, however, ULP-F was not sure if a dosing card was available for measuring diclofenac sodium 1% gel at this location. ULP-F removed R5's diclofenac sodium 1% gel box from the house number one medication cart and located the diclofenac sodium 1% gel dosing card in the box. On December 16, 2025, at 12:15 p.m., LPN-A stated ULPs were trained to use the ruler (dosing card) each time diclofenac sodium 1% gel was administered to ensure the correct amount was applied to the resident. On December 17, 2025, at 9:16 a.m., regional registered nurse (RRN)-I stated ULPs were trained and expected to use the dosing card for measuring diclofenac sodium 1% gel. The manufacturer's instructions for Voltaren (diclofenac sodium) dated July 2009, indicated the proper amount of Voltaren Gel should be measured using the dosing card supplied in the drug product carton. In addition, the dosing card should be used for each application of drug product. The licensee's 2.00 Medication Management Services policy dated January 16, 2023, indicated when administration of medications is delegated to ULPs the assisted living facility must ensure that the registered nurse (RN) has instructed the ULP in the proper methods to administer the medications, and the ULP has demonstrated the	01760		

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01760	Continued From page 20 ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two refrigerators (R5's refrigerator) storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. 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 December 15, 2025, at 12:46 p.m., licensed practical nurse	01880		

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01880	Continued From page 21 (LPN)-A stated the licensee provided medication management to residents at the facility. R5's AL (assisted living)- Medication Management Plan dated December 5, 2025, indicated R5's medications were stored in a locked medications cart, locked medication room, and R5 self-administered and stored R5's Trulicity injection in R5's refrigerator. R5's Medication Administration Record dated November 2025, and December 2025, respectively, indicated Perforomist 20 mcg/2 milliliters (mL) twice daily. Medication needs to be refrigerated. Medication is in resident room fridge. On December 16, 2025, at 9:32 a.m., the surveyor observed unlicensed personnel (ULP)-F provide scheduled morning medication administration for R5. ULP-F opened R5's refrigerator, removed one vial of Performist 20 mcg/2 mL, and stated R5's Performist vials were stored in R5's refrigerator along with R5's Trulicity. ULP-F stated ULP-F did not know the current temperature of R5's refrigerator and ULP-F was not sure if the refrigerator temperature was monitored or not. On December 16, 2025, at 12:17 p.m., LPN-A stated the licensee managed and administered R5's Perforomist 20 mcg/2 mL, however, the licensee was not monitoring R5's refrigerator temperature. LPN-A further stated the licensee would not know if R5's Perforomist was being stored appropriately as the refrigerator temperature was not being monitored. On December 17, 2025, at 9:18 a.m., regional registered nurse (RRN)-I stated all refrigerators storing resident medications managed by the	01880		

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01880	Continued From page 22 licensee were supposed to be checked daily for the current temperature and documented, however, RRN-I stated R5's refrigerator temperature was not being monitored. The manufacturer's instructions for Perforomist dated May 2010, indicated Perforomist to be stored between 36 degrees Fahrenheit (F) and 77 degrees F. The licensee's 2.00 Medication Management Services policy dated January 16, 2023, indicated (licensee name) will store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 monitor for expired medications in two of two locked medication carts (house number one and house number two).	01890		

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01890	Continued From page 23 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 15, 2025, at 12:46 p.m., licensed practical nurse (LPN)-A stated the licensee provided medication management to residents at the facility. HOUSE NUMBER ONE On December 16, 2025, at 7:05 a.m., the surveyor reviewed the medication cart located in house number one with unlicensed personnel (ULP)-H and observed an expired open package of stock Imodium 2 milligrams (mg). ULP-H stated the Imodium expired September 2025, and the nurse checked the cart "a lot" for expired medications. HOUSE NUMBER TWO On December 16, 2025, at 7:11 a.m., the surveyor reviewed the medication cart located in house number two with ULP-C and observed the following: -an opened tube of pain-relieving cream with an expiration of November 2025 for an unidentified resident; and -six stock loperamide 2 mg tablets with an expiration date of June 2025. Immediately following the observation, ULP-C	01890		

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01890	Continued From page 24 stated the LPN checked the medication carts weekly. On December 16, 2025, at 12:11 p.m., LPN-A stated LPN-A checked the medication carts weekly for expired medications, however, LPN-A had an oversight of missing the expired medications noted above. On December 17, 2025, regional registered nurse (RRN)-I stated the registered nurse (RN) and LPN were expected to check medications weekly and remove any expired medications from the medication cart. The licensee's 2.00 Medication Management Services policy dated January 16, 2023, indicated (licensee name) will store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions. In addition, the policy indicated the facility shall dispose of any expired medications. The licensee's 2.01 Storage of Medications policy dated January 16, 2023, indicated all prescription medications stored outside of the client's (resident's) private living space must be in a securely locked and in a substantially constructed compartment according to manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02280 SS=C	144G.90 Subd. 5 Notice to residents; change in ownership or m	02280		

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02280	Continued From page 25 (a) A facility must provide written notice to the resident, legal representative, or designated representative of a change of ownership within seven calendar days after the facility receives a new license. (b) A facility must provide prompt written notice to the resident, legal representative, or designated representative, of any change of legal name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the manager of the facility, if applicable; and (2) the authorized agent. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice to the residents, legal representative, or designated representative of a change of ownership (CHOW) with all required content. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 15, 2025, at 12:42 p.m., assisted living director in residency (ALDIR)-J stated the licensee was familiar with current minimum assisted living requirements.	02280		

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BUHL CAREFREE LIVING BY OXFORD LIVING	500 EAST MONROE DRIVE BUHL, MN 55713

(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
02280	Continued From page 26 The licensee had a CHOW effective April 29, 2025. The licensee provided a copy of a CHOW letter to residents and families dated March 21, 2025, which identified the licensee's president, chairman, and director of operations. The letter did not include the manager of the facility, if applicable, or the authorized agent for the licensee. On December 16, 2025, at 12:06 p.m., licensed practical nurse (LPN)-A stated all residents received the CHOW letter. On December 17, 2025, at 9:12 a.m., regional registered nurse (RRN)-I stated the CHOW letter provided by the licensee did not include all required content for the notification of CHOW. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02280		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

BUHL CAREFREE LIVING BY OXFORD
500 East Monroe Drive
Buhl, MN 55713
St Louis County
Parcel:

Phone: 218-258-8681
benjaminc@spectrumchealth.com

License Info

License: HFID 26432
Benjamin Castegneri
Risk: Medium
License:
Expires on:
CFPM: Benjamin F. Castegneri
CFPM #: 12048; Exp: 12/6/2028

Inspection Info

Report Number: F7983251136
Inspection Type: Full - Single
Date: 12/15/2025 Time: 1:35:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) Raw shell eggs are pasteurized.

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 Duluth District Office inspection report number F7983251136 from 12/15/2025

Davin Nordahl
Person in Charge

Gary Collyard,
Public Health Sanitarian 3
218-302-6147
gary.collyard@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

BUHL CAREFREE LIVING BY OXFORD
Buhl
County/Group: St Louis County

Inspection Info

Report Number: F7983251136
Inspection Type: Full
Date: 12/15/2025
Time: 1:35:00 PM

Food Temperature: Product/Item/Unit: Raw Shell Egg**; Temperature Process:** Cold-Holding
Location: Samsung Refrigerator/Freezer-Refrigerator Compartment- at 37 Degrees F.
Comment: House 2.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Foods Frozen**; Temperature Process:** Cold-Holding
Location: Samsung Refrigerator/Freezer-Freezer Compartment- at N/A Degrees F.
Comment: House 2.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Tomato-Basil Soup-Bagged**; Temperature Process:** Cold-Holding
Location: Arctic Air Single-Door Upright Refrigerator-Left- at 40 Degrees F.
Comment: House 2.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Diced Ham**; Temperature Process:** Cold-Holding
Location: Arctic Air Single-Door Upright Refrigerator-Right- at 41 Degrees F.
Comment: House 2.
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Wash Water**; Temperature Process:** Warewashing
Location: Warewashing Machine at 162 Degrees F.
Comment: House 2.
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Rinse Water**; Temperature Process:** Warewashing
Location: Warewashing Machine at 180 Degrees F.
Comment: House 2.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Foods Frozen**; Temperature Process:** Cold-Holding
Location: Menard Single-Door Upright Freezer at N/A Degrees F.
Comment: House 1.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Foods Frozen**; Temperature Process:** Cold-Holding
Location: Maytag Single-Door Upright Freezer at N/A Degrees F.
Comment: House 1.
Violation Issued?: No

Food Temperature: Product/Item/Unit: Foods Frozen**; Temperature Process:** Cold-Holding
Location: Frigidaire Chest Freezer at N/A Degrees F.
Comment: House 1.
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: Raw Shell Egg**; Temperature Process:** Cold-Holding
Location: Maytag Refrigerator/Freezer-Refrigerator Compartment- at 36 Degrees F.
Comment: House 1.
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: Foods Frozen**; Temperature Process:** Cold-Holding
Location: Maytag Refrigerator/Freezer-Freezer Compartment- at N/A Degrees F.
Comment: House 1.
Violation Issued?: No

<u>Equipment Temperature</u>: Product/Item/Unit: Utensil Surface Temperature**; Temperature Process:** Warewashing
Location: Warewashing Machine at 160 Degrees F.
Comment: House 2.
Violation Issued?: No

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Duluth, MN 55802

Sanitizer Observations/Recordings

Establishment Info

BUHL CAREFREE LIVING BY OXFORD
Buhl
County/Group: St Louis County

Inspection Info

Report Number: F7983251136
Inspection Type: Full
Date: 12/15/2025
Time: 1:35:00 PM

Sanitizing Chemical: **Product:** Quaternary Ammonium**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 400 PPM
Comment: House 2.
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL26432017-0	**Date:** December 16, 2025
Facility Name: BUHL CAREFREE LIVING BY OXFORD	
Facility Address: 500 EAST MONROE DRIVE, BUHL, MN 55713	

☒ **TAG IDENTIFICATION: 0775**

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

1. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Several burnt cigarettes had been disposed of on the ground in the designated resident smoking area near the main entrance to the 500 building. One burnt cigarette was disposed of along the foundation of the building.

2. Emergency lighting shall be continuously maintained. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.10]

   Comments: Director of maintenance (DM)-D stated the emergency lights were not working at the main entrance doors for the 500 and 502 buildings, and the licensee was already working with an electrician to make the necessary repairs.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: The number identifiers posted on the doors for resident rooms 10, 11, 14, and 17 were not visible as the numbers were covered by decorations. Resident sleeping room identifiers shall be visibly installed on or at all resident room doors and correspond with the floor plan to provide efficient communication for exiting in the event of a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire safety and evacuation plan (FSEP) lacked evacuation procedures for the individualized unique needs of residents. Residents requiring staff assistance in an emergency had been identified but these procedures were maintained electronically on the computer and not included in the FSEP.