Electronically Delivered

March 28, 2025

Licensee
Buhl Carefree Living LLC
500 East Monroe Drive
Buhl, MN 55713

RE: Project Number(s) SL26432016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

REQUESTING A HEARING

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

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

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

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

JMD

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 _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHL CAREFREE LIVING LLC	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 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: SL26432016 On February 24, 2025, through February 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 18 residents 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to develop a staffing plan that included metrics to identify staffing to meet scheduled and unscheduled needs of residents. This had the potential to affect all residents, staff, and visitors. 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	0 470		

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0 470	Continued From page 2 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of 20 residents and had a current census of 18 residents. On February 24, 2025, at 9:30 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated all 18 residents received services. On February 24, 2025, at 9:45 a.m., CNS-C stated the usual staffing schedule for the facility was as follows: - the day shift was staffed with two unlicensed personnel (ULP) from 6:30 a.m. to 2:30 p.m. - the afternoon shift was staffed with two ULPs from 2:30 p.m. to 10:30 p.m. - the night shift was staffed with one ULP from 10:30 p.m. to 6:30 a.m. On February 24, 2025, at 10:00 a.m., during a tour of the facility with CNS-C. CNS-C stated the facility consisted of House One and House Two. The two houses were connected by a common's area. On February 24, 2025, at approximately 10:15 a.m., the surveyor reviewed the staffing plans dated January 14, 2025, and July 9, 2024, respectively. The staffing pattern indicated: - staff have the required experience, training and competency to provide care and services provided to residents as appropriate for their	0 470		

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0 470	Continued From page 3 position. - there was 24-hour, awake staff available to respond to resident requests for assistance with health and safety needs. Requirements for staff are available in the staffing policy. - between the hours of 10:30 p.m. and 6:30 a.m., there would be direct-care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. These staff will be in the same building in order to respond within a reasonable amount of time. - the adequate number of staff is determined by reviewing the services needed by all the residents. Staffing schedules will reflect the determination of what is needed for adequate number of staff. - day shift two (RA/ resident assistant, (ULP) 6:30 a.m., until 2:30 p.m., every day. one ULP on House One, one ULP on House Two. - evening shift: two ULPs 2:30 p.m., until 10:30 p.m., every day, one ULP on House One, one ULP on House Two. - night shift: one-two ULP's 10:30 p.m., until 6:30 a.m., to cover House One and House Two (dependent upon census). - Monday-Friday typical nursing coverage included: - 40 hours RN coverage- on site or available remotely if at shared location. - 40 hours licensed practical nurse (LPN) coverage. - licensed staff on-call for ULP personnel 24 hours a day. On February 24, 2025, at 10:26, the licensee's staffing plan was reviewed with CNS-C. CNS-C stated there was nothing written down, and no metric was used to determine staffing needs.	0 470		

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0 470	Continued From page 4 CNS-C stated she "just knows" and motioned to her head of what staff was needed and when. The licensee's Staffing and Scheduling policy dated August 1, 2021, noted Health Services Manager RN (registered nurse) would ensure a written staffing plan would be developed and implemented that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The RN must ensure that staffing levels were adequate to address the following: - each resident's needs, as identified in the resident's service plan and assisted living contract - each resident's acuity level, as determined by the most recent assessment or individualized review -the ability of staff to timely meet the resident's scheduled and reasonable foreseeable unscheduled needs given the physical layout of the facility premises - where the facility had a secured dementia care unit, and - staffs experience, training, and competency. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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	0 510		

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0 510	Continued From page 5 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 ensure infection control standards were followed by one of two unlicensed personnel (ULP)-B during vital sign monitoring. 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: ULP-B was hired on November 8, 2024, to provide direct care services to the facility's residents. ULP-B's employee record indicated ULP-B had received competency training to include infection control, disinfecting reusable equipment and surfaces on November 19, 2024. On February 24, 2025, from 11:17 a.m., until 11:26 a.m., the surveyor continuously observed ULP-B.	0 510		

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0 510	Continued From page 6 On February 24, 2025, at 11:17 a.m., the surveyor observed a blood pressure (BP) machine positioned on top of the medication cart. ULP-B stated she was documenting R5's blood pressure of 123/76. The surveyor did not observe ULP-B sanitize the BP machine. On February 24, 2025, at 11:18 a.m., the surveyor observed ULP-B pick up the BP machine and go to R6's room. ULP-B placed the BP cuff around R6's upper left arm and obtain a BP reading of 139/104. The surveyor did not observe ULP-B sanitize the BP cuff. On February 24, 2025, at 11:24 a.m., the surveyor observed ULP-B take the BP machine to R4's room. ULP-B placed the BP cuff on R4's upper left arm and obtain a BP reading of 128/85. The surveyor did not observe ULP-B sanitize the BP cuff. On February 24, 2025, at 11:26 a.m., ULP-B stated the BP cuff should be wiped down after each resident use. ULP-B stated she should have wiped down the BP cuff after each use but did not. On February 24, 2025, at 12:06 p.m., clinical nurse supervisor (CNS)-C stated the BP cuff should be cleaned after each use. CNS-C stated it was possible ULP-B was nervous being watched and forgot to clean the BP cuff. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated October 9, 2017, noted: - after using reusable equipment, the equipment must be cleaned and returned to the place that it is stored	0 510		

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0 510	Continued From page 7 - shared glucometers must be cleaned after each use following the manufacturer's instructions. - put on gloves - clean any obvious soiled material with paper towels and soapy water - spray with premixed sterilizing solution of 1:10 bleach solution or sterilizing product approved the registered nurse. 1:10 bleach solution is caustic. Avoid direct contact with skin and eyes. Allow the equipment to air dry on a clean paper towel - return the equipment to proper storage location - small equipment may be cleaned using alcohol prep pads or disinfectant wipes. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

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0 650	Continued From page 8 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for one of one employee (unlicensed personnel (ULP)-E). 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: ULP-E was hired on October 21, 2024, to provide direct care services to the facility's residents. On February 25, 2025, at 6:27 a.m., the surveyor observed R5 ask for something to drink; ULP-E went to the kitchen area, removed a glass from the cupboard, and filled the glass with water from the refrigerator. ULP-E took the glass of water to R5. ULP-E went to the medication cart and ULP-E documented the amount of water given to R5 on a form. ULP-E stated the registered nurse (RN) had talked to her, (trained her) on R5's fluid restrictions. ULP-E added they (ULPs) had "cheat sheets" to use for the amounts each glass held.	0 650		

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0 650	Continued From page 9 ULP-E stated the form used for documentation of R5's fluid intake was nice, as the form allowed ULPs to "see" the entire amount of fluid R5 drank for the day. ULP-E's employee record included training for the following topics, dated November 5, 2024: - feeding assist - meal cueing - meal set-up - modified diet/ thicken food/liquid. ULP-E's employee record did not include documentation of training for fluid restrictions. On February 25, 2025, at 8:03 a.m., the surveyor reviewed ULP-E's training record with clinical nurse supervisor (CNS)-C. CNS-C stated she completed training on fluid restrictions with ULPs. CNS-C stated she would look in other records to see if she could find documentation of the training. On February 25, 2025, at 10:25 a.m., CNS-C stated all ULPs were trained and deemed competent on fluid restrictions however there was no evidence of fluid restriction training in ULP records. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom	0 650		

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0 650	Continued From page 10 style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. The licensee's Employee Record Requirements policy dated November 12, 2024, noted the facility must maintain current records of each paid staff member. The records must include the following information: records of orientation, required annual training and infection control training, and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775		

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0 775	Continued From page 11 by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on February 25, 2025, from 9:45 a.m. to 11:00 a.m., with director of maintenance (DM)-G, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: ELECTRICAL EXTENSION CORDS There was electrical extension cords routed through the doorway providing power to the nurse carts outside the office in building one and building two. Electrical power cords shall be overcurrent protected power strips and providing power to appliances located in the same room, not routed through building elements or doorways. Electrical extension cords used for temporary power are required to be provided in accordance with MSFC in Minnesota Rules Chapter 7511. ELECTRICAL CONNECTION BOX COVERS	0 775		

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0 775	Continued From page 12 There was an electrical extension cord that was altered and being used to supply power to one of the boiler pumps in the boiler room of building two. There was also electrical connection box covers missing the cover, exposing electrical connections on the pumps and control equipment for the hot water boiler heating system in the boiler room of building two. There was electrical connection box covers missing, exposing the electrical connections on two hot water boiler heating system pumps in the boiler room in building one. During the facility tour DM-G, stated parts were on order to replace some of the boiler heating system parts in buildings one and two, that is why the extension cord was used and the covers were removed. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 13 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 810		

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0 810	Continued From page 14 On February 25, 2025, at 9:15 a.m., licensed assisted living director in residence (LALDIR)-F, regional registered nurse (RRN)-E, and director of maintenance (DM)-E, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP dated February 18, 2025, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on February 25, 2025, at 9:25 a.m., LALDIR-F, and RRN-E, stated specific actions required of residents and resident unique needs for evacuation in the event of a fire or similar emergency were not available in the FSEP. TRAINING	0 810		

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0 810	Continued From page 15 Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by not providing documentation the employee training was completed twice per year as required. Documentation was provided training was completed for employees one time in 2024 on April 4, 2024, only. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the training was provided to residents as required. During an interview on February 25, 2025, at 9:35 a.m., LALDIR-F, and RRN-E, and DM-G, stated documentation was not available indicating training was completed by employees and provided to residents as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date 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	01640		

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01640	Continued From page 16 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 service plans were revised to include provided services for two of three residents (R5, R6). 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: R5 R5's diagnoses included diabetes, hypertension (HTN/high blood pressure), atrial fibrillation (a-fib/an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), and congestive heart failure (CHF/condition in which the heart's function as a pump is inadequate to meet the body's needs).	01640		

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01640	Continued From page 17 R5's service plan dated September 26, 2024, included: - blood pressure (BP): obtain and record resident blood pressure and pulse daily at noon. If systolic BP (top number) is greater than 160, wait 20 minutes and re-check. Report to nurse if BP greater than 160/90, or less than 90/50 and pulse greater than 100 or less than 50 - monthly vital signs (BP, pulse, temperature, weight, oxygen saturation). On February 24, 2025, at 11:17 a.m., the surveyor observed a BP machine positioned on top of the medication cart. ULP-B stated she was documenting R5's blood pressure of 123/76. R5's medication administration record (MAR) dated February 1, 2025, through February 24, 2025, included: -6:00 a.m.: digoxin (a-fib), take one table by mouth daily, notify nursing if heart rate less than 60. R5's prescriber order dated December 24, 2024, included the above order. R5's pulse monitoring dated February 1, 2026, though February 24, 2025, included: -pulse was monitored 24 opportunities -pulse ranged from 74-97. R5's service plan was not revised as required, to include BP monitoring with medication administration at 6:00 a.m. On February 25, 2025, at 10:25 a.m., R5's service plan was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated R5's pulse monitoring with digoxin was a service the licensee provided and R5's service plan was not	01640		

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01640	Continued From page 18 revised to include daily pulse monitoring at 6:00 a.m., daily. R6 R6's diagnoses included diabetes, HTN, and orthostatic hypotension (BP drops when standing or sitting up). R6's service plan dated November 13, 2023, included: -monthly vital signs (BP, pulse, temperature, weight, oxygen saturation). On February 24, 2025, at 11:18 a.m., the surveyor observed ULP-B take the BP machine to R6's room. ULP-B placed the BP cuff around R6's upper left arm and obtained a BP reading of 139/104. R6's February 1, 2025, through February 24, 2025, MAR included: - 12:00 p.m.: daily BP checks, left arm only, inform nursing if BP greater than 180/100 or less than 40/60, take at least on hour after administering a.m. medications. R6's prescriber order dated December 26, 2024, included the above order. R6's service plan was not revised as required, to include daily BP monitoring. On February 25, 2025, at 11:16 a.m., R6's record was reviewed with CNS-C. CNS-C stated she did not "see" BP monitoring on R6's service plan. CNS-C stated she had sent an updated service plan to R6's contact however the service plan was not returned, in October 2024. CNS-C added she had completed an assessment in January 2025, for R6, and she (CNS-C) should have	01640		

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01640	Continued From page 19 made sure R6's service plan was up to date. CNS-C confirmed R6's service plan was not revised as required. The licensee's Service Plan policy dated January 16, 2023, noted a service plan means the written plan between a resident or resident's designated representative and the facility about the services that would be provided to the resident. The service plan and any revisions shall include a signature or another authentication by the licensee and by the resident, or resident's representative, documenting agreement of the services to be provided. Service plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=E	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	01750		

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01750	Continued From page 20 by: Based on observation, interview and record review, the licensee failed to provide specific resident instructions related to the administration of medications for two of three residents (R3, 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 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: R3 R3's diagnoses included diabetes and allergic rhinitis due to pollen. R3's service plan dated December 1, 2023, included: - insulin injections, four times daily - medication administration, ten times daily. On February 24, 2025, at 11:27 a.m., the surveyor observed unlicensed personnel (ULP)-B take a Novolog 100 units/milliliter (ml) (short-acting insulin) pen and a bottle of Refresh (dry eye) solution to R3's room. ULP-B injected three units of Novolog into R3's left upper arm and instilled an eye drop into each of R3's eyes. Directly after the above observation R3's medication administration record (MAR) was reviewed with ULP-B. ULP-B stated R3's MAR	01750		

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01750	Continued From page 21 did not have an area to document insulin injection site. ULP-B stated R3 liked Novolog insulin administered in her (R3) upper arm. ULP-B stated R3 had more than one eye drop, and the times of administration varied. INSULIN ADMINISTRATION R3's MAR dated February 1, 2025, through February 24, 2025, included: - Lantus (long-acting insulin) 100 units/ml, inject 38 units subcutaneous (SQ/under the skin into fatty tissue) every morning. - Novolog 100 units/ml inject three units SQ three times daily with meals. Hold if blood sugar is under 100. Administer five to ten minutes before meals. If resident refuses meal, alert nursing. R3's prescriber order dated December 24, 2024, included the above medication. R3's MAR did not include - manufacturer's instruction for injectable medication: site rotation. On February 24, 2025, at 12:06 p.m., clinical nurse supervisor (CNS)-C stated she thought there was a place to document injection sites in resident records. The manufacturer's instructions for Lantus dated August 2022, noted change (rotate) your injection sites within the area you choose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection site. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. The manufacturer's instructions for Novolog	01750		

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01750	Continued From page 22 dated January 2019, noted rotate injections between injection spots, do not inject into the same spot every time. EYE DROPS ADMINISTRATION R3's MAR dated February 1, 2025, through February 24, 2025, included: - Restasis 0.05% (dry eyes) instill one drop in both eyes twice daily: 7:00 a.m., 6:00 p.m. - Refresh Classic instill one drop into both eyes four times daily: 7:30 a.m., 11:30 a.m., 4:30 p.m. 7:00 p.m. - olopatadine 0.2% (allergies) place one drop into each eye one time daily 8:30 a.m. - latanoprost 0.005% (high eye pressure) instill one drop in both eyes at bedtime: 7:30 p.m. R3's MAR did not include: - manufacturer's instructions for eye drops: wait in-between each type of drop. On February 24, 2025, at 2:11 p.m. CNS-C stated ULPs had an hour on either side of the listed medication administration time to administer resident's medication. CNS-C stated there was no direction in R3's MAR to allow time in-between each eye drop. CNS-C confirmed with the one-hour time allowance for medication administration ULPs could give more than one eye drop at the same time. CNS-C confirmed R3's record did not include specific instructions for eye drop administration. The manufacturer's instructions for Restasis dated November 7, 2023, noted the typical dose of Restasis is one drop in each eye twice a day, about 12 hours apart. If you also use other eye drops, it's best to separate them for Restasis by at least 15 minutes. If you use eye ointments, you should use Restasis first, wait 15 minutes, and	01750		

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01750	Continued From page 23 then apply the ointment. The manufacturer's instructions for Refresh Classic dated September 2016, noted if you use Refresh with another eye medicine, leave at least 15 minutes between putting Refresh and the other medicine. Use any eye ointment or eye gel last. The manufacturer's instructions for olopatadine dated May 15, 2020, noted if using another eye product, wait at least five minutes after using olopatadine eye drops before using the other eye medications. The manufacturer's instructions for latanoprost dated February 1, 2023, noted if you will be using latanoprost with other eye medicines, use them at least five minutes apart from each other. R5 R5's diagnoses included diabetes, hypertension (HTN/high blood pressure, atrial fibrillation (a-fib/an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), and congestive heart failure (CHF/condition in which the heart's function as a pump is inadequate to meet the body's needs). R5's serviced plan dated September 26, 2024, included: - medication administration, five times daily. R5's medication administration record (MAR) dated February 1, 2025, through February 24, 2025, included: - Admelog (short acting insulin) 100 units/ml inject three units SQ three times daily with meals, hold for blood sugars less than 100. - Basaglar (long-acting insulin) 100 units/ ml,	01750		

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01750	Continued From page 24 infect 45 units SQ at bedtime. R5's prescriber's order dated December 24, 2024, included the above order. On February 25, 2025, at 7:05 a.m., the surveyor observed ULP-E check R5's right leg wound. ULP-E stated R5's wound was slow to heal and R5 was not supposed to have juice. On February 24, 2025, at 1:40 p.m., R3's MAR was reviewed with CNS-C and regional registered nurse (RRN)-D. CNS-C and RRN-D stated R3's MAR did not include specific instructions for R3's insulin administration, to include site administration. The surveyor asked to review R5's MAR, for insulin site instruction. CNS-C reviewed R5's record and stated R5's MAR did not include specific instructions for R5's insulin administration, to include site administration. The manufacturer's instructions for Admelog dated November 2019, noted change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy and localized cutaneous amyloidosis at the injection sites. The manufacturer's instructions for Basaglar dated July 2021, noted change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy and localized cutaneous amyloidosis at the injection sites. The licensee's Medication Management Services policy dated January 16, 2023, noted when administration of medications was delegated to ULP, the assisted living facility must ensure that the registered nurse had, specified, in writing,	01750		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01750	Continued From page 25 specific instruction for each resident and documented those instructions in the resident's records. No further information 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 insulin was administered per the manufacturer's instructions for one of three residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01760		

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	26432	A. BUILDING: _____ B. WING _____	02/26/2025

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01760	Continued From page 26 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: R3's diagnoses included diabetes. R3's service plan dated December 1, 2023, included: - insulin injections, four times daily. R3's medication administration record (MAR) dated February 1, 2025, through February 24, 2025, included: - Lantus (long-acting insulin) 100 units/milliliters (ml), inject 38 units subcutaneous (SQ/under the skin into fatty tissue) every morning - Novolog (short acting insulin) 100 units/ml inject three units SQ three times daily with meals. Hold if blood sugar is under 100. Administer five to ten minutes before meals. If resident refuses meal, alert nursing. R3's prescriber order dated December 24, 2024, included the above medication. On February 25, 2025, at 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-E review R3's MAR and take R3's morning medication to R3's room which included Lantus and Novolog pens (a multiple dose pen shaped injector device used for insulin administration). ULP-E checked R3's blood glucose level using correct technique. ULP-E cleaned the tip of R3's Lantus pen with an alcohol pad, applied a needle, dialed the pen to two units, and pushed the plunger on the insulin pen. ULP-E dialed the Lantus pen to 38 units,	01760		

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01760	Continued From page 27 removed the needle guard, cleaned an area on R3's abdomen and injected the insulin. ULP-E picked up the Novolog insulin pen, cleaned the tip of the pen with an alcohol pad, applied a needle, dialed the pen to two units, and pushed the plunger on the insulin pen. ULP-E dialed the Novolog pen to three units, removed the needle guard, cleaned an area on R3's left arm and injected the insulin. ULP-E did not remove the needle guard and check for insulin prior to insulin administration. R3's insulin pens were not primed correctly prior to use (air bubbles removed from the needle and to ensure that the needle was open and working). On February 25, 2025, at 7:46 a.m., ULP-E stated she normally took the cover off of the insulin pen and checked for insulin flow. ULP-E stated she should have completed that step but added she did not perform that step during R3's insulin administration. ULP-E stated she had no excuse since she had been doing "this stuff" (medication administration) for over ten years. On February 25, 2025, at 8:18 a.m., clinical nurse supervisor (CNS)-C stated ULP-E should have ensured the insulin pens worked prior to insulin administration. CNS-C stated ULP-E should have removed the caps on the needles and looked for insulin flow. The manufacturer's instructions for the use of Lantus insulin pens, dated 2022, noted: - removed the pen cap with clean hands - wipe the pen tip with an alcohol swab, removed the protective seal from the new needle. Line the needle up straight with the pen and screw the needle-on. After you have attached the needle, take off the outer needle cap and save it (you will	01760		

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01760	Continued From page 28 need it to remove the needle after injection) removed the inner needle cap and throw it away - dial a test does of two units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubble rose to the top of the needle. This will help you get the most accurate dose. Press the infection button all the way in and check to see that insulin came out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin came out, repeat the test two more times. If there is still no insulin came out, use a new needle and do the safety test again. - always perform the safety test before each injection - never use the pen if no insulin comes out after using a second needle. The manufacturer's instructions for the use of Novolog insulin pens, dated January 2019, noted - select a dose of two units - take off the outer needle cap (save it) and inner needle cap (throw it away) - with the pen pointing up, tap the insulin to move the air bubbles to the top - press the button all the way in and make sure insulin comes out of the needle - repeat up to two more times with the same needle if needed - if insulin does not come out after three times, change the needle and try again - if insulin still does not come out after changing the needle, the pen may be broken. The licensee's Medication Management policy dated January 16, 2023, noted when administration of medication s was delegated to ULP, the assisted living facility must ensure that the registered nurse had: - instructed the ULP in the proper methods to	01760		

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01760	Continued From page 29 administer the medications, and the ULP had demonstrated the 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 medications were securely stored during the medication administration process by one of two unlicensed personnel (ULP)-E) for one of four residents (R7). 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: R7's diagnoses included inflammatory demyelinating polyneuritis (autoimmune	01880		

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01880	Continued From page 30 disease/nerve damage, weakness, and loss of sensation), acute and chronic respiratory failure, and abdominal hernia (condition where part of an internal organ protrudes through a weakness in the abdominal wall). R7's service plan dated January 29, 2024, included medication administration twice daily. Checking resident's medication record, preparing the medication as necessary, administering the medication to the resident, document the administration or reason for not administering the medications. Reporting to a nurse any concerns about the medications, the resident, or the resident's refusal to take the medication. R7's medication administration record (MAR) dated February 1, 2025, through February 24, 2025, included: -albuterol AER HFA, (respiratory failure) inhale two puffs into the lungs twice daily, 8:00 a.m. - fiber-lax 625 milligrams (mg) (bowel health), 8:00 a.m. - losartan potassium 100 mg (heart/high blood pressure), 8:00 a.m. R7's prescriber order dated December 24, 2024, included the above orders. R7's medication management plan dated February 13, 2025, included: - the resident is able to safety store some medications independently: powder kept in bathroom - medications are stored in a locked medications cart: medications are stored in locked medication room, powder in bathroom - medication administration by facility staff. On February 25, 2025, at 7:16 a.m., the surveyor	01880		

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01880	Continued From page 31 observed ULP-E preparing R7's morning medication, to include an albuterol AER HFA inhaler with spacer, losartan, and fiber-lax medication. On February 25, 2025, at 7:22 a.m., ULP-E took the medications to R7's room to administer. ULP-E knocked on the door and entered R7's room. R7 was in the bathroom. ULP-E stated she normally waited in R7's room, "but I (ULP-E) will go put the medications by his table and he (R7) will page when he is ready. ULP-E asked R7 to "let me (ULP-E) know when you are ready (for medication administration)." On February 25, 2025, at 7:24 a.m., ULP-E returned to the medication cart and placed the albuterol inhaler into the locked medication cart and stated she normally did not leave medication in R7's room. On February 25, 2025, at 9:32 a.m., clinical nurse supervisor (CNS)-C stated she would have taken R7's medication cup back to the medication cart and secured the medications and not left the medication in R7's room. CNS-C stated, "you never know what could happen, who could walk in (to R7's room)." The licensee's Medication Management policy dated January 16, 2023, noted a registered nurse must conduct a nursing assessment of a resident's request for medication management services, including the appropriate way to store the resident's medication and whether secured storage was appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion or other consideration. In the resident's individualized medication management plan, the registered	01880		

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01880	Continued From page 32 nurse may identify the need for secured storage of medication within the resident's private living space or centrally stored within the assisted living site. The licensee would 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=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 medication was maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications in one of two medication carts (House One.) 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	01890		

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01890	Continued From page 33 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, 2025, at 9:56 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-C, to include two locked medication carts, House one, House Two. CNS-C observed and confirmed the following: - an opened Anoro Ellipta 62.5/25 micrograms (mcg) inhaler (chronic inflammatory lung disease (COPD/ obstructed airflow from the lungs) for R2 undated. On February 24, 2025, at 10:11 a.m., CNS-C stated R2's Anoro inhaler should have been dated to include an open date and an expiration date. The manufacturer's instructions for Anoro Ellipta inhaler dated August 2020, noted do not open the cover of the inhaler until you are ready to use it. Write the "tray opened" and "discard" dates on the inhaler label. The "discard" date is six weeks from the date you open the tray. The licensee's Medication Management policy dated January 16, 2023, noted a prescription drug 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01950	Continued From page 34	01950		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating nursing tasks, the registered nurse (RN) trained unlicensed personnel (ULP) and had ULP demonstrate the ability to follow the procedure for one of one ULP (ULP-E). Additionally, the licensee failed to ensure the RN prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R5, R6) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01950		

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01950	Continued From page 35 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: ULP-E ULP-E was hired on October 21, 2024, to provide direct care services to the facility's residents. On February 25, 2025, at 7:01 a.m., the surveyor observed ULP-E monitor R5's temperature, 97.3 Fahrenheit (F). ULP-E also looked at the dressing on R5's right leg and asked R5 for current pain level. ULP-E's record lacked evidence of receiving training and/or demonstrating competency for cold packs and warm packs, however, R5 and R6's records indicated the use of cold and warm packs as needed (PRN) and ULP-E had been assigned to provide services to both residents. On February 25, 2025, at 10:25 a.m., clinical nurse supervisor (CNS)-C and regional registered nurse (RRN)-D stated no training or competencies were completed for cold packs. CNS-C and RRN-D stated cold packs were in the standing orders (written protocols signed by prescriber that authorize health care team to complete certain clinical tasks with having to first obtain an order) used by the licensee. CNS-C stated there were no warm packs used at the facility. The surveyor reviewed R6's record with CNS-C and RRN-D. CNS-C stated no training or competencies were completed for warm packs.	01950		

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01950	Continued From page 36 CNS-C confirmed the licensee failed to complete training and competencies for cold/warm packs as required. R5 R5's diagnoses included diabetes, hypertension (HTN/high blood pressure, atrial fibrillation (a-fib/an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), and congestive heart failure (CHF/condition in which the heart's function as a pump is inadequate to meet the body's needs). R5's serviced plan dated September 26, 2024, included: -medication administration, five times daily. R5's treatment/therapy management plan dated November 19, 2024, included: brace/orthotics. R5's assessment dated December 24, 2024, included: -does the resident have any non-pharmacological pain treatments? -yes: ice packs. R5's medication administration record (MAR) dated February 1, 2025, through February 24, 2025, included: -cold compress, apply cold pack topically to affected area for 10-15 minutes, PRN (as desired or as needed), for pain/swelling - apply/removed knee brace: staff to apply hinge style knee brace to resident's left and right knee daily in the morning PRN. Apply utilizing top, middle, and bottom Velcro to secure. Open circle area goes directly on knee R6 R6's diagnosis included diabetes, dementia, and	01950		

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01950	Continued From page 37 osteoarthritis. R6's service plan dated November 13, 2023, included: medication administration, three times daily. R6's MAR dated February 1, 2025, through February 24, 2025, included: - cold compress, apply cold pack topically to affected area for 10-15 minutes, PRN, for minor discomfort, bump or contusions - warm compress, apply warm compress topically to affected area for 10-15 minutes PRN, for minor discomfort, bump or contusions. R6's prescriber order dated December 26, 2024, included the above orders. On February 25, 2025, at 10:25 a.m., CNS-C and RRN-D stated resident records did not include specific instructions for cold/warm pack use to include do not place cold/ ice packs on direct skin. RRN-D stated she was not sure what the licensee would use for warm packs. On February 25, 2025, at 10:30 a.m., CNS-C stated R5's brace order was two to three years old. CNS-C stated R5 bought the brace and did not like it or use it. RR-D stated the order was current and on R5's MAR and R5's record should include specific instructions for use, such as what and when to report issues or concerns with R5's brace. The licensee's Treatment and Therapy Management Services policy dated January 16, 2023, noted when administration of a treatment or therapy was delegated or assigned to ULP, the facility would ensure that the RN or authorized licensed health professional had:	01950		

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01950	Continued From page 38 -instructed the ULP in the proper methods with respect to each resident and the ULP had demonstrated the ability to competently follow the procedures: -specified, in writing, specific instructions for each resident and documented those instructions in the resident's record -had procedures for notifying a RN or appropriate licensed health professional when a problem arose with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not and any follow up procedures that were provided to meet the resident's needs for two of two residents (R5,	01960		

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(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
01960	Continued From page 39 R6) with health monitoring managed by the provider. 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: R5 R5's diagnoses included diabetes, hypertension (HTN/high blood pressure, atrial fibrillation (a-fib/an irregular and often very rapid heart rhythm that can lead to blood clots in the heart), and congestive heart failure (CHF/condition in which the heart's function as a pump is inadequate to meet the body's needs). R5's serviced plan dated September 26, 2024, included: - blood pressure (BP): obtain and record resident blood pressure and pulse daily at noon. If systolic BP (top number) is greater than 160, wait 20 minutes and re-check. Report to nurse if BP greater than 160/90 or less than 90/50, and pulse greater than 100 or less than 50. - monthly vital signs (BP, pulse, temperature, weight, oxygen saturation). On February 24, 2025, at 11:17 a.m., the surveyor observed a BP machine positioned on top of the medication cart. ULP-B stated she was documenting R5's blood pressure of 123/76.	01960		

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 _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHL CAREFREE LIVING LLC	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
01960	Continued From page 40 R5's medication administration record (MAR) dated February 1, 2025, through February 24, 2025, included: -BP and pulse: obtain and record resident BP and pulse daily at noon. If systolic BP (top number) is greater than 160, wait 20 minutes and re-check. Report to nurse if BP greater than 160/90 or less than 90/50, and pulse greater than 100 or less than 50. R5's prescriber's order dated December 24, 2024, included the above order. R5's record included BP monitoring from January 1, 2025, through February 25, 2025: - BP was recorded 59 times - recorded BPs ranged from 96/63 to 156/146 - 12 recorded BPs were out of range - 12 of 12 readings did not include documentation the nurse was notified as directed. - Pulse monitoring from January 1, 2025, through February 25, 2025: - pulse was recorded 56 times - recorded pulse ranged from 69-135 - 13 recorded pulses were out of range - 13 of 13 reading did not include documentation that the nurse was notified as directed. R6 R6's diagnoses included diabetes, HTN, and orthostatic hypotension (BP drops when standing or sitting up). R6's service plan dated November 13, 2023, included: -monthly vital signs R6's service plan did not include daily BP	01960		

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 _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHL CAREFREE LIVING LLC	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
01960	Continued From page 41 monitoring. On February 24, 2025, at 11:18 a.m., the surveyor observed ULP-B place the BP cuff around R6's upper left arm and obtain a BP reading of 139/104. R6's February 1, 2025, through February 24, 2025, MAR included: - 12:00 p.m.: daily BP checks, left arm only, inform nursing if BP greater than "180/100 or less than 40/60", take at least one hour after administering a.m.(morning) medications. R6's record did not indicate if 180/100 and 40/60 referred to systolic reading (upper number/heart while at work) or diastolic reading (lower number/heart at rest). R6's record included BP monitoring from February 1, 2025, through February 24, 2025: - BP was recorded 24 times - recorded BPs ranged from 96/52, 115/43, to 135/104 - 2 recorded BPs were out of range - 2 of 2 reading did not include documentation that the nurse was notified as directed. On February 25, 2025, at 10:50 a.m., R5's BP and pulse monitoring was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated she was not informed of R5's out of range readings. In addition, R6's record was reviewed with CNS-C. CNS-C stated she was not informed of R6's BP reading of 139/104 collected February 24, 2025. CNS-C confirmed ULPs were not reporting when R5's monitoring was out of range. CNS-C stated ULPs do report out of range monitoring for other residents. CNS-C added there would be documentation if nursing had been updated as required.	01960		

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 _____	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHL CAREFREE LIVING LLC	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
01960	Continued From page 42 The licensee's Treatment and Therapy Management Services policy dated January 16, 2023, noted when administration of a treatment or therapy was delegated or assigned to ULP, the facility would ensure that the RN or authorized licensed health professional had: -instructed the ULP in the proper methods with respect to each resident and the ULP had demonstrated the ability to competently follow the procedures -communicated with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/24/25*
Time: 10:00:00
Report: 7983251053

Food and Beverage Establishment Inspection Report

Location:
Buhl Carefree Living Llc - 501 - House 2
500 East Monroe Drive
Buhl, MN55713
St. Louis County, 69

Establishment Info:
ID #: 0037736
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182588681
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at N/A Degrees Fahrenheit
Location: Spray bottle.
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the Samsung refrigerator/freezer was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 39 Degrees Fahrenheit - Location: Raw pasteurized shell egg in the refrigerator compartment of the Samsung refrigerator/freezer.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Butter in the left Arctic Air single-door upright refrigerator.

Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Cream cheese in the right Arctic Air single-door upright refrigerator.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 165 Degrees Fahrenheit - Location: Wash water temperature.
Violation Issued: No

Type: Full
Date: *02/24/25*
Time: 10:00:00
Report: 7983251053
Buhl Carefree Living Llc - 501 - House 2

Food and Beverage Establishment Inspection Report

Process/Item: Warewashing Machine
Temperature: 186 Degrees Fahrenheit - Location: Rise water temperature.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 160 Degrees Fahrenheit - Location: Utensil surface temperature.
Violation Issued: No

Process/Item: Reheating
Temperature: 166 Degrees Fahrenheit - Location: Precooked chicken cordon bleu for immediate service.
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
0	0	0	0

==========

GENERAL COMMENTS:

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) Provided an illness reporting fact sheet, an employee illness decision guide, an employee illness log, and a vomit cleanup poster.

3) Raw shell eggs are pasteurized.

4) TCS food is served the day of preparation. Any leftovers are for staff only.

5) Food prepared from raw include beef in stew, pork chops, chicken breast, and hamburgers.

==========

Type: Full
Date: *02/24/25*
Time: 10:00:00
Report: 7983251053
Buhl Carefree Living Llc - 501 - House 2

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7983251053 of 02/24/25.

Certified Food Protection Manager: Benjamin Castegneri

Certification Number: FM86771 Expires: 12/06/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Rick Webster
Cook / PIC

Signed: 7983
Gary Collyard
Public Health Sanitarian III
218-940-9306
gary.collyard@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/24/25*
Time: 10:00:00
Report: 7983251052

Food and Beverage Establishment Inspection Report

Location:
Buhl Carefree Living Llc - 502 - House 1
500 East Monroe Drive
Buhl, MN55713
St. Louis County, 69

Establishment Info:
ID #: 0037736
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182588681
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the refrigerator/freezer was frozen solid.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 35 Degrees Fahrenheit - Location: Raw pasteurized shell egg in the refrigerator compartment of the refrigerator/freezer.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Menard single-door upright freezer was frozen solid.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the Maytag single-door upright freezer was frozen solid.
Violation Issued: No

Process/Item: Reheating
Temperature: 147 Degrees Fahrenheit - Location: Precooked chicken cordon bleu for immediate service.
Violation Issued: No

Type: Full
Date: *02/24/25*
Time: 10:00:00
Report: 7983251052
Buhl Carefree Living Llc - 502 - House 1

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

==========

GENERAL COMMENTS:

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) Provided an illness reporting fact sheet, an employee illness decision guide, an employee illness log, and a vomit cleanup poster.

3) Raw shell eggs are pasteurized.

4) TCS food is served the day of preparation. Any leftovers are for staff only.

5) Food prepared from raw include beef in stew, pork chops, chicken breast, and hamburgers.

6) The warewashing machine was inoperable at the time of inspection.

==========

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 7983251052 of 02/24/25.

Certified Food Protection Manager: Benjamin Castegneri

Certification Number: FM86771 Expires: 12/06/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Mark Hachka
Cook / PIC

Signed: 7983
Gary Collyard
Public Health Sanitarian III
218-940-9306
gary.collyard@state.mn.us