Electronically Delivered

August 6, 2024

Licensee
Glenn Buffalo
201 1st Street Northeast
Buffalo, MN 55313

RE: Project Number(s) SL20395015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	20395	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENN BUFFALO	201 1ST STREET NE BUFFALO, MN 55313

(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: SL20395015-0 On July 8, 2024, through, July 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 51 resident(s); 51 receiving services under the provider's 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 08, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 2 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. 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 the residents). The findings include: The licensee's undated emergency preparedness	0 680		

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0 680	Continued From page 3 plan (EPP), lacked the required content: - a process for emergency preparedness (EP) collaboration with local, tribal, regional, state and federal EP officials to maintain integrated response; - the development of policies/procedures to address: - procedures for medical documents; and - roles under a waiver declared by the secretary. - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - communication plan that included primary and alternate means of communicating with: facility staff and federal, state, tribal, regional & local emergency management agencies; and - a quarterly review of missing resident policy. On July 10, 2024, at 9:50 a.m., licensed assisted living director (LALD)-A agreed their emergency preparedness plan was missing some of the required content and did not say why. The licensee's Emergency Preparedness Plan policy dated April 15, 2022, indicated the community emergency preparedness plan will include all required elements of appendix Z. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided.	0 680		

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0 680	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms inside resident sleeping units throughout the facility including the interconnection of smoke alarms in the	0 780		

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0 780	Continued From page 5 one-bedroom resident units. This has the potential to directly affect all residents, staff, and visitors in the building. 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 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 residents). The findings include the following: On July 11, 2024, from approximately, 10:15 a.m. and 2:30 p.m., survey staff toured the facility with the director of maintenance (DM)-F, the director of maintenance (DM)-G, the licensed assisted living director (LALD)-A, and the regional director of operations (RDOF)-H. During the facility tour, survey staff observed the following: -Inside each resident sleeping studio unit throughout the building, survey staff observed a hardwired smoke detector rather than the required smoke alarm to sound inside each room for local notification. The DM-G and the DM-F could not verbally confirm that the smoke detectors would sound inside each sleeping unit. The DM-G stated that they understand smoke alarms are required inside each resident sleeping room and must sound for local notification. The DM-G verified the findings and noted that they are considering a battery type smoke alarm in each resident sleeping room. -Inside resident one-bedroom units, 180 and 280, no smoke alarms were observed in the sleeping	0 780		

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0 780	Continued From page 6 rooms. Both units had hardwired smoke detectors were installed outside of the sleeping room rather than the required smoke alarms to sound for local notification. Survey staff explained to the DM-G and the DM-F that the interconnection of smoke alarms is also required for the one-bedroom units. The DM-G verified the findings and stated that the DM-G understands that both smoke alarms in the unit need to be interconnected. Survey staff also reviewed additional documentation, Brothers Fire and Security, dated October 23, 2023, and the report indicated that the smoke detectors inside resident rooms were not tested throughout the facility. On July 11, 2024, at 3:00 p.m., survey staff explained the deficient findings and the DM-F, the DM-G, the LALD-A, and the RDOF-H understood and acknowledged the findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	0 790		

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0 790	Continued From page 7 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to properly maintain all portable fire extinguishers and to properly secure and mount the Type K portable fire extinguisher. This had the potential to directly affect residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On July 11, 2024, from approximately, 10:15 a.m. and 2:30 p.m., survey staff toured the facility with the director of maintenance (DM)-F, the director of maintenance (DM)-G, the licensed assisted living director (LALD)-A, and the regional director of operations (RDOF)-H. During the facility tour, survey staff observed the following: INSTALLATION -The portable fire extinguisher (PE), Type K unit, in the kitchen was not properly secured and mounted. Survey staff observed the PE was improperly located on the floor under the three-compartment sink. SERVICE/MONTHLY INSPECTIONS	0 790		

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0 790	Continued From page 8 -The PE, Type K unit, improperly located on the floor of the kitchen had a tag that showed service date of October 2023, but no records of monthly inspections were available for review. -The second kitchen PE unit mounted next to the door had a tag that showed service date of October 2023, but no records of monthly inspections were available for review. The DM-F stated that he had thought he inspected all PE units in the building. -The mounted PE unit near room 118 had not been serviced since October 2020 and no monthly inspection records. The tag attached to this PE unit showed a service date of October 2020, and no other records were available for review at the time of discovery. -The mounted PE unit located on the second floor had not been annually service since October 2022. The attached tag that showed service date of October 2022, and no other records were available for review at the time of discovery. On July 11, 2024, at 3:00 p.m., survey staff explained the deficient findings and the DM-F, the DM-G, the LALD-A, and the RDOF-H understood and acknowledged the findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	0 800		

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0 800	Continued From page 9 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On July 11, 2024, from approximately, 10:15 a.m. and 2:30 p.m., survey staff toured the facility with the director of maintenance (DM)-F, the director of maintenance (DM)-G, the licensed assisted living director (LALD)-A, and the regional director of operations (RDOF)-H. On facility tour, survey staff observed the following: -The first-floor stairway door near room 181 failed to positively latch when closed to maintain the required fire rating. The hardware was missing a door striker. The DM-G wrote an electronic work order to for repair at the time of discovery.	0 800		

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0 800	Continued From page 10 -The rubbish storage room door failed to positively latch when closed. The DM-G wrote an electronic work order for repair at the time of discovery. -The first- and second-level laundry room doors were completely removed and opened to the corridor comprising the corridor for safe egress. The findings were evident as the door strike plates remained on the door frame openings. -The three corridor doors separating the corridor from the dining room had been removed, and the dining room is opened to the corridor. The findings were evident as the door strike plates remained on the door frame opening. -Throughout the facility, the self-closing door hardware on the resident room corridor doors were tampered or disconnected to prevent doors from self-closing. The findings were evident as there were still some hardware remaining on top of the doors and frames. -The drain standpipe (receiving washer discharge and emergency eyewash) inside the second-floor laundry room did not have the required drain trap to prevent sewer gas from entering the environment. The DM-G wrote an electronic work order to fix the plumbing at the time of discovery. -The abandoned standpipe in the dietician's office was not capped to prevent sewer gas from continuously entering the room and building environment. The standpipe was used to serve a clothes washer. -The joint between the toilet bowl and the bathroom floor in resident room 188 was no	0 800		

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0 800	Continued From page 11 longer intact for proper cleaning of the perimeter of toilet bowl and floor. Survey staff explained that the joint needed to be re-caulked for cleaning around the toilet bowl and the DM-G agreed. -The second-floor resident wing bathroom exhaust vents where resident rooms 218, 226, and 240 are located, were not operational and had no air movement. The DM-G wrote an electronic work order at the time of discovery to address the findings. The DM-G verified the findings and stated that they just repaired two exhaust fans and the non-operational fan must be from a different exhaust fan. -No bathroom exhaust vent in resident 102. The DM-G commented that this part of the building was part of the original hospital before the other building additions. -The improper use of the shower compartment for storage in resident room 284. The DM-G agreed and commented that they frequently discuss this practice to discourage the residents from storing inside showers.. -The water supply control valves for the bathtub in the tub room and the two-compartment sink (near room 210) on the second-floor level were removed with the drains uncapped and not properly abandoned which would allow sewer gas to enter the room and building environment. -The ceiling penetrations (20 inches by 15 inches and 6 inches by 4 inches) were observed in the corridor ceiling of the dining room and also, inside the storage room across from the community room that had the potential to comprise the proper fire rating construction of the storage room as well as maintaining the integrity of the corridor	0 800		

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0 800	Continued From page 12 and fire separation between the two stories. Survey staff asked about the ceiling penetrations and the DM-G stated that they had roof leakage and working on repairs, and they had received a quote from a roof contractor to look at the roof for repair (Roof Spec Inc., dated June 10, 2024). The DM-G verified the findings at the time of discovery. -In resident rooms 216, 218, 236, and 204 had peeling paint from water damage. The DM-G explained again that the damage issues are related to the roof leaking and they have a quote from a roof contractor to look at the roof for repair (Roof Spec Inc., dated June 10, 2024). -No carbon monoxide detection/alarm devices were observed in the building corridors or the mechanical/boiler rooms. The appliances and boilers are of fuel-burning type. The DM-F and the DM-G understood the safety of having carbon monoxide-detecting devices but could not locate any. The DM-F agreed to review this finding with the local fire department when they come for a walkthrough. -The boiler room stairway exiting to the outside was stacked with boxes obstructing the door. The DM-F confirmed the finding and stated that they just had a delivery. -The door with a built-in grille in the kitchen, located between the three-compartment sink and the range hood was blocked from access with a cart. After the blockage was cleared from the door and the door was unlocked, the door led down to an unused lower-level room. Survey staff explained to the DM-G and the DM-F that the lower-level room was not maintained and was filled with dirt, potential growth of mold, and	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20395	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENN BUFFALO	201 1ST STREET NE BUFFALO, MN 55313

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0 800	Continued From page 13 unknowns that can circulate into the kitchen where meals are prepared through the door grille. The DM-G and the DM-F acknowledged and stated they do not access or use this room. -The mechanical room and maintenance shop doors located on the basement level next to the theater room had self-closing hardware that was disconnected to prevent the doors from self-closing properly. -Improper storage of furniture (tables and chairs) at the stair landings in the basement level next to the theater room. -In the basement maintenance shop, plug strips were improperly used by daisy-chained with multiple extensions to power the microwave. RESIDENT ROOM 105 -The carpet was heavily stained and soiled. - The toilet room was cluttered with stacked supplies and clothes, and not in a cleanliness condition. In addition, the toilet bowl had dark stains and uncleaned. - No exhaust ventilation in the toilet room. The LALD-A stated that they routinely clean the resident's (105) room but could not provide documented records of the cleaning when survey staff asked. The above deficient findings were verified by the LALD-A, the RDOF-H, DM-G, and the DM-F at the time of discovery during the facility tour. On July 11, 2024, at 3:15 p.m., survey staff during the exit interview, explained the deficient findings and the DM-F, the DM-G, the LALD-A, and the RDOF-H understood and acknowledged the	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20395	A. BUILDING: _____ B. WING _____	07/11/2024

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GLENN BUFFALO	201 1ST STREET NE BUFFALO, MN 55313

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0 800	Continued From page 14 findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
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) employee 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) Employees 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 employees twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20395	A. BUILDING: _____ B. WING _____	07/11/2024

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GLENN BUFFALO	201 1ST STREET NE BUFFALO, MN 55313

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0 810	Continued From page 15 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 record review and interview, the licensee failed to provide the minimum required employee training on fire safety and evacuation and the minimum evacuation drills. This has the potential to directly affect the safety of staff, visitors, and all residents receiving care. 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). The findings include: On July 11, 2024, at approximately 3:00 p.m., document review and interview on facility fire safety and evacuation plan and related documentation with the director of maintenance (DM)-F, the director of maintenance (DM)-G, the licensed assisted living director (LALD)-A, and the regional director of operations (RDOF)-H indicated the following: -No documentation was available for review for fire evacuation drills for calendar year 2023. Drill records provided for the review were for 2024. -No documentation was available for review for employee training on the facility's fire safety and evacuation for calendar year 2023. The LALD-A verified the findings and indicated all staff are	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 16 scheduled for 2024 training. On July 11, 2024, at 3:15 p.m., survey staff explained the deficient findings and the DM-F, the DM-G, the LALD-A, and the RDOF-H acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20395	A. BUILDING: _____ B. WING _____	07/11/2024

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GLENN BUFFALO	201 1ST STREET NE BUFFALO, MN 55313

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01620	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 admitted to the licensee on June 13, 2018, and began receiving assisted living services on August 1, 2021. R3's diagnoses included type II diabetes, essential hypertension, atherosclerotic heart disease, peripheral vascular disease, and incomnia. R3's Service Agreement dated May 21, 2024, indicated R3 received services for medication administration, safety checks, housekeeping, and laundry. R3's record included 90- day assessments dated December 19, 2023, March 19, 2024, and June 24, 2024. The following R3 90- day assessment was	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20395	A. BUILDING: _____ B. WING _____	07/11/2024

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01620	Continued From page 18 completed late: -June 24, 2024, by 7 days. On July 10, 2024, at 9:30 a.m., the clinical nurse supervisor (CNS)-B stated the assessment was a few days late and she must have just missed the date for it. The licensee's Initial and On-Going Nursing Assessment of Resident dated October 27, 2021, indicated the RN will determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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	20395	A. BUILDING: _____ B. WING _____	07/11/2024

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GLENN BUFFALO	201 1ST STREET NE BUFFALO, MN 55313

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01940	Continued From page 19 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on June 24, 2023. R1's diagnoses included diabetes, heart failure,	01940		

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	20395	A. BUILDING: _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENN BUFFALO	201 1ST STREET NE BUFFALO, MN 55313

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01940	Continued From page 20 depression, and anxiety. R1's master assessment dated May 29, 2024, indicated R1 received assistance with blood glucose checks three times a day per prescriber's orders. R1's prescriber orders dated October 4, 2023, included: - blood glucose check three times daily. Notify nurse if blood sugar is below 70 or above 400. R1's medication administration record (MAR) dated June 2024, included Accu-Chek Nano Smartview strip - Use to test blood glucose three times daily. R1's Individualized Treatment or Therapy Management Plan, failed to include the following required content: - Documentation of specific resident instructions relating to the treatments or therapy administration; and - Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. On July 9, 2024, at 11:45 a.m., the surveyor observed unlicensed personnel enter R1's apartment to obtain a blood glucose reading and record in R1's record. On July 10, 2024, at 9:00 a.m., clinical nurse supervisor (CNS)-B stated R1's treatment plan for blood glucose checks was missing the parameters for a high or low reading and when the staff should notify the nurse and this must have been missed when the service was added for R1.	01940		

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01940	Continued From page 21 The licensee's Development of the Individualized Therapy/Treatment Plan policy revised October 27, 2021, indicated are clinical nurse specialist/registered nurse will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - A statement of the type of services that will be provided; - Documentation of specific resident instructions relating to the treatments or therapy administration; - Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - Any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *07/08/24*
Time: 12:49:25
Report: 1041241150

Food and Beverage Establishment Inspection Report

Location:
Glenn Buffalo
201 1st Street Ne
Buffalo, MN55313
Wright County, 86

Establishment Info:
ID #: 0038030
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636825489
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.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C1 ***** Priority 1 *****

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

THE DISHWASHER MEASURED 0 PPM CHLORINE AT TIME OF INSPECTION. REPAIR DISHWASHER. SANITIZE DISHES IN THE SINK WITH QUAT SANITIZER UNTIL THE DISHWASHER IS REPAIRED.

Comply By: 07/08/24

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

DISHWASHER MEASURED 148 DEG. F. AT TIME OF INSPECTION. MICHELLE AND REPAIR TECH ARE AWARE THE DISHWASHER IS NOT REACHING TEMPERATURE AND ARE USING THE CHEMICAL SYSTEM (CHLORINE) TO SANITIZE IN THE DISHWASHER UNTIL WATER TEMP CAN REACH 160 DEG. F.

Comply By: 07/08/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PROVIDE CHLORINE AND QUAT TEST STRIPS.

Comply By: 07/22/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

LABEL ALL BULK BINS (FLOUR, SUGAR, BREAD CRUMBS, ETC.)

Comply By: 07/08/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

THERE WAS A BOX OF EGGS ON THE FLOOR IN THE WALK-IN COOLER AND A BOX OF POPCORN KERNELS ON THE FLOOR IN THE DRY STORAGE ROOM. STORE FOOD ON SHELVES.

Comply By: 07/08/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

PROVIDE A THERMOMETER IN THE WALK-IN COOLER.

Comply By: 07/15/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE GASKET ON THE WALK-IN COOLER IS TORN. REPLACE GASKET.

Comply By: 08/26/24

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

PANS ARE BEING STACKED WHILE WET. ALLOW DISHES TO AIR DRY COMPLETELY BEFORE STACKING.

Comply By: 07/08/24

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

REPAIR THE LEAKING FAUCET ON THE TWO COMPARTMENT SINK.

Comply By: 08/19/24

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

REPAIR OR REPLACE DETERIORATING METAL FLOOR PANEL IN THE KITCHEN BY THE TWO COMPARTMENT SINK.

Comply By: 01/08/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

CLEAN THE FLOOR, PAYING EXTRA ATTENTION TO THE FLOOR UNDER THE COOKLINE EQUIPMENT.

Comply By: 07/29/24

Surface and Equipment Sanitizers

Chlorine: = 0 PPM at Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: Yes

Hot Water: = at 149 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: Yes

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: TWO COMPARTMENT SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: SWEET POTATOES
Violation Issued: No

Type: Full
Date: *07/08/24*
Time: 12:49:25
Report: 1041241150
Glenn Buffalo

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 158 Degrees Fahrenheit - Location: PORK CHOPS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: PEA SALAD
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 41 Degrees Fahrenheit - Location: SLICED HAM
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 41 Degrees Fahrenheit - Location: BEEF TIPS IN GRAVY
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	8

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 1041241150 of 07/08/24.

Certified Food Protection Manager: MICHELLE MILLER

Certification Number: 13710 Expires: 08/18/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Linda Heinen
Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us

Report #: 1041241150

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/08/24
Time In 12:49:25
Time Out

	Address	City/State	Zip Code	Telephone
Glenn Buffalo	201 1st Street Ne	Buffalo, MN	55313	7636825489

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038030		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight	
2	IN OUT N/A	Certified food protection manager, duties	
Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting	
4	IN OUT	Proper use of reporting, restriction & exclusion	
5	IN OUT	Procedures for responding to vomiting & diarrheal events	
Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use	
7	IN OUT N/O	No discharge from eyes, nose, & mouth	
Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed	
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed	
10	IN OUT	Adequate handwashing sinks supplied/accessible	
Approved Source			
11	IN OUT	Food obtained from approved source	
12	IN OUT N/A N/O	Food received at proper temperature	
13	IN OUT	Food in good condition, safe, & unadulterated	
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction	
Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected	
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized	
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food	

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

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
Food Identification				
37	X	Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Food Recalls:

Person in Charge (Signature) **Date:** 07/08/24

Inspector (Signature) Linda Hinen