Electronically Delivered

October 22, 2026

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

RE: Project Number(s) SL20395016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 10, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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.

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

CLN

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 _____	09/10/2026

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

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0 000	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: SL20395016-0 On September 8, 2026, through September 10, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 61 residents; 61 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 9, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 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 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 775		

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0 780	Continued From page 4	0 780		
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 780		

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0 780	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 780		
0 800 SS=I	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 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, interview, and record review, the licensee failed to ensure the physical	0 800		

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0 800	Continued From page 6 environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 800		
0 810 SS=C	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 7 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 ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 810		

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0 810	Continued From page 8 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated September 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 810		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures	01500		

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01500	Continued From page 9 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-F). 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	01500		

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01500	Continued From page 10 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-F ULP-F was hired April 8, 2025, to provide direct care services to residents. ULP-F's employee records lacked evidence annual training had been completed as required in the following areas: - review of provider's policies and procedures; and - infection control techniques. On September 9, 2026, at 1:15 p.m., regional director of operations (RDO)-G stated she agrees they do not have any documentation of ULP-F's annual review of policies and procedures or infection control training for 2026. RDO-G stated this is because they give the employees until the end of the calendar year to finish all the required training, as an incentive for it to be completed on time they will deduct points from their annual performance review and annual increase for each month the training is late beyond their employment start date. RDO-G stated if the employees have not completed the training by the end of the calendar year, they are taken off the schedule. RDO-G agreed the statue requirement for annual training was with each 12 months of employment. The licensee's Assisted Living with Memory Care Annual Training policy dated August 1, 2021,	01500		

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01500	Continued From page 11 indicated All of our assisted living employees will complete annual education on the following topics: - infection control techniques used in the home and implementation of infection control standards; and - review of policies and procedures relating to the provision of assisted living services and how to implement them. Direct-care staff will complete 8 hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01760 SS=E	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 medication	01760		

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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
01760	Continued From page 12 administration was completed as prescribed for two of two residents (R3 and R7) with topical application of medication. 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 was admitted to the licensee on September 30, 2025, with diagnoses which included Type 2 diabetes, memory loss, major depressive disorder and dysphagia (difficulty swallowing). R3's service plan dated September 30, 2025, indicated R3 received assistance with medication administration. R3's provider orders dated August 26, 2026, included an order for diclofenac sodium 1% topical gel, four (4) grams, apply topically to right lower back and leg twice a day. On September 9, 2026, at 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications for R3. ULP-E applied a small amount of diclofenac sodium 1% topical gel to her gloved hand and proceeded to apply it onto R3's lower back. ULP-E failed to measure the dose of the gel applied onto R3. ULP-E stated she had never been taught to use the	01760		

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 _____	09/10/2026

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
01760	Continued From page 13 measurement tool included in the medication box and always squeezes some into her gloved hand and applies it to the affected area. On September 9, 2026, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated staff should be using the measurement tool when administering the diclofenac gel, they have been taught to use the tool and if the staff did not use the tool they probably just forgot to use it. R7 R7 was admitted to the licensee on June 13, 2018, and began receiving assisted living services August 1, 2021, with diagnoses which included Type 2 diabetes with diabetic neuropathy, dry eye syndrome and dementia. R7's service plan dated September 9, 2026, indicated R7 received assistance with medication administration. R7's provider orders dated January 7, 2026, included an order for arthritis pain 1% topical gel (diclofenac sodium), apply one (1) gram topically to bilateral knees twice a day. On September 9, 2026, at 8:30 a.m. the surveyor observed ULP-C administer medications for R7. R7 received blood glucose monitoring, insulin, arthritis pain relief topical gel, nasal spray, and oral medications. During observation, ULP-C applied small amount of pain relief gel to gloved hand and applied it to R7's knees. ULP-C did not measure dose of medication given. ULP-C stated this was his normal practice, and that he had been trained to measure the medication, however there was no measuring device available.	01760		

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 _____	09/10/2026

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
01760	Continued From page 14 On September 9, 2026, at 9:20 a.m. CNS-B stated all topical medications should be measured and R7 should have had a measurement strip for the medication. CNS-B stated it was expected that staff would notify nursing if the measurement strip was not available. The licensee's Medication Errors policy, dated January 25, 2023, indicated staff are to report any medication error to the registered nurse (RN) and the RN will investigate any errors and implement corrective action to reduce the risk of similar medication errors in the future. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01870		

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 _____	09/10/2026

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
01870	Continued From page 15 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 was admitted to the licensee on June 13, 2018, and began receiving assisted living services August 1, 2021, with diagnoses which included Type 2 diabetes, dry eye syndrome and dementia. R7's service plan dated September 9, 2026, indicated glucose checks three times a day, insulin administration two times a day, oral medications four times a day, and topical medications two times a day. R7's medication management assessment dated August 31, 2026, indicated staff would administer some or all medications and the resident did not plan to self-administer any medications. On September 9, 2026, at 8:30 a.m. the surveyor observed unlicensed personnel (ULP)-C administer medications for R7. R7 received blood glucose monitoring, insulin, arthritis pain relief topical gel, nasal spray, and oral medications. During observation, ULP-C opened nasal spray and handed medication to R7 to self-administer. ULP-C also prepared the insulin pen by placing and priming a needle and drawing up the correct dose of insulin before handing the pen to R7 to self-administer. ULP-C stated this was his normal practice, and the nurse would let him know if someone was able to self-administer	01870		

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 _____	09/10/2026

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
01870	Continued From page 16 medications. On September 9, 2026, at 9:20 a.m. clinical nurse supervisor (CNS)-B stated all residents should be assessed prior to being able to self-administer medications and an order from the provider should be obtained. CNS-B stated the electronic medical record would indicate if a resident was able to self-administer medications. CNS-B confirmed R7 was not assessed for self-administration and did not have an order to self-administer medications. The licensee's Initial and On-Going Nursing Assessments of Residents Under the Comprehensive Licensed Agency policy, dated July 27, 2021, indicated the registered nurse (RN) will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: - pre-admission assessment in person; - 14-day assessment: completed up to 14-days after start of services and will be conducted in person; - ongoing assessment: completed periodically but no less than every 90-days; and - change in resident condition. A comprehensive assessment includes but may not be limited to the requirements outlined by the Minnesota rules. Comprehensive assessment will include: - self-administration vs other types of administration; and - resident preferences for taking medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		

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 _____	09/10/2026

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
01880	Continued From page 17	01880		
01880 SS=F	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 all medications were stored according to manufacturer's instructions in the medication refrigerator. This had the potential to affect all the licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 8, 2026, at 8:30 a.m., the surveyor observed the medication refrigerator on the second floor and noted the reading was 52° Fahrenheit (F). Temperature log on attached to the front of the refrigerator was filled out with all readings within the temperature range indicated. Unlicensed personnel (ULP)-C confirmed the refrigerator was above temperature and stated it was unplugged when he arrived at the start of his shift today.	01880		

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	20395	A. BUILDING: _____ B. WING _____	09/10/2026

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

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01880	Continued From page 18 Medication refrigerator contained: 7 pens of Insulin glargine (long acting insulin) 14 pens of insulin novolog (a rapid acting insulin) 2 pens of Novolin (a brand name of insulin) 2 pens of Insulin Lispro Kwikpen 3 Mounjaro injections (a once weekly injectable medication for type 2 diabetes) 1 injection of Repatha SureClick (an injection to help control "bad" cholesterol) 1 bottle of Magic mouthwash (a prescription mouthwash used for mouth sores) 1 bottle of Latanoprost eyedrops (an eyedrop used to control high eye pressure) All manufacturers' guidance for storage is to be refrigerated at 36-46° F. During interview on September 9, 2026, at 9:20 a.m., clinical nurse supervisor (CNS)-B stated if there was an issue with the refrigerator, she would want to know right away. CNS-B confirmed 52° F would be outside of the appropriate temperature range, and the medications would have to be reviewed with a pharmacist to see which ones were still safe to be used. The licensee's Storage of Medications policy, dated December 29, 2022, indicated when secure storage of medications is necessary, the RN will identify based upon assessment where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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 _____	09/10/2026

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GLENN BUFFALO	201 1ST STREET NE BUFFALO, MN 55313

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01890	Continued From page 19	01890		
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 date time-sensitive medications with an opened or expired date for one of three residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On September 9, 2026, at 9:30 a.m., the surveyor observed one of the three medication carts on the fist floor of the building with unlicensed personnel (ULP-E) and observed one Lantus insulin pen and one Humalog insulin pen for R8 which had a date sticker that indicated the pen was only good for 28 days but did not contain an open date written on the pen. ULP-E confirmed both pens had been opened and used and did not contain an open date on the sticker. ULP-E stated the	01890		

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 _____	09/10/2026

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

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01890	Continued From page 20 staff that opens the insulin pens are supposed to put the date it was opened and first used on the sticker. On September 9, 2026, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated insulin pens should be labeled with the open date when staff first use the pen and the two insulin pens found without the date on them must have been missed by the staff that opened them. The manufacturer's instructions for the Lantus insulin pen dated May 2025 indicated only use your pen for up to 28 days after its first use. Throw away the Lantus Solostar pen you are using after 28 days, even if it still has insulin left in it. The manufacturer's instructions for the Humalog insulin pen dated July 2023 indicated throw away the insulin pen you are using after 28 days, even if it still has insulin left in it. The licensee's Storage of Medications policy dated December 29, 2022, indicated Until the medication is set up for immediate or later administration by a nurse, the medication must be kept in its original container bearing their original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescribers, state of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

GLENN BUFFALO
201 1ST STREET NE
Buffalo, MN 55313
Wright County
Parcel:

Phone:
tgraupmann@gentletouchhealth.com

License Info

License: HFID 20395

Risk:
License:
Expires on:
CFPM: Brandon Smith
CFPM #: 62733; Exp: 11/10/2028

Inspection Info

Report Number: F7930261274
Inspection Type: Full - Single
Date: 9/8/2026 Time: 11:16:40 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 7
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.11A *Priority Level: Priority 3 CFP#: 39*
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.
COMMENT: A PREVIOUSLY OPENED BAG OF PANKO BREAD CRUMBS WERE STORED DIRECTLY ON THE FLOOR. STORE UP OFF OF THE FLOOR IN A CONTAINER.
Comply By: 9/8/2026 Originally Issued On: 9/8/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: SMALL PREP COOLER ACROSS FROM COOK LINE:
DELI MEAT MEASURED 54 DEG F AND SHREDDED CHEESE MEASURED 55 DEG F. ALL TCS FOOD WAS DISCARDED ON SITE. REPAIR TO MAINTAIN TEMPERATURES AT 41 DEG F OR BELOW. DO NOT ADD ANY TCS FOOD TO THE COOLER UNTIL THE UNIT MEASURES 41 DEG F OR BELOW.
Comply By: 9/8/2026 Originally Issued On: 9/8/2026

New Order: 4-200 Equipment Design and Construction
4-201.11 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0505 Replace equipment or utensils that are not durable or do not retain their characteristic qualities under normal use conditions.
COMMENT: REPLACE THE FLOUR STORAGE BIN. THE WHEELS HAVE FALLEN OFF ONE SIDE AND THE BIN NOW SITS ON THE FLOOR ON THAT SIDE.
Comply By: 9/15/2026 Originally Issued On: 9/8/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: CLEAN THE OUTER SURFACES OF THE DISHWASHER TO REMOVE EXCESSIVE BUILD UP.
Comply By: 9/10/2026 Originally Issued On: 9/8/2026

New Order: 5-200A Plumbing: approved materials/design
5-201.11B *Priority Level: Priority 3 CFP#: 51*
MN Rule 4626.1040B Maintain the plumbing system in good repair.
COMMENT: REPAIR THE LEAK ON THE FAUCET AT THE PREP SINK.
Comply By: 9/15/2026 Originally Issued On: 9/8/2026

New Order: 6-100 Physical Facility Construction Materials
6-101.11A1 *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.
COMMENT: 1) REPLACE THE MISSING FLOORING IN THE DISHWASHING ROOM INCLUDING UNDER THE DISHWASHER.
2) REPLACE THE MISSING FLOOR TILES IN FRONT OF THE WALK-IN FREEZER.
3) REPAIR THE PEELING WALL AND CEILING IN THE DRY STORAGE ROOM IN THE HALL.
4) REPAIR THE PEELING CEILING IN THE DISHWASHING ROOM.

Comply By: 10/8/2026 Originally Issued On: 9/8/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-303.11C *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1470C Provide at least 50 foot candles (540 LUX) of light intensity for areas where food employees are working with utensils and equipment where safety is a factor.
COMMENT: REPLACE THE BURNED OUT LIGHT BULBS IN THE VENTILATION HOOD.
Comply By: 9/10/2026 Originally Issued On: 9/8/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: 1) REMOVE DUST BUILD UP ON THE WALL BEHIND BEVERAGE MACHINES IN THE KITCHEN.
2) DISHWASHING ROOM: REMOVE DUST BUILD UP ON THE CEILING. CLEAN DISHWASHING ROOM FLOOR INCLUDING UNDER THE DISHWASHER AREA AND CLEAN DISHWASHING ROOM WALLS TO REMOVE BUILD UP.
Comply By: 9/11/2026 Originally Issued On: 9/8/2026

Food & Beverage General Comment

DISCUSSION ITEMS:
EMPLOYEE ILLNESS LOG AND COOLING PROCESS.

E-MAILED WITH REPORT:
COOLING FACT SHEET

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F7930261274 from 9/8/2026

Tina Remmele

Establishment Representative

Tina Remmele,
Public Health Sanitarian 3
320-223-7302
tina.remmele@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

GLENN BUFFALO
Buffalo
County/Group: Wright County

Inspection Info

Report Number: F7930261274
Inspection Type: Full
Date: 9/8/2026
Time: 11:16:40 AM

Food Temperature: Product/Item/Unit: DELI MEAT **; Temperature Process:** Cold-Holding
Location: Prep Cooler at 54 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: SHREDDED CHEESE**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 55 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: ROAST BEEF**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: TORTELLINI**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: BBQ**; Temperature Process:** Hot-Holding
Location: Steam Table at 165 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

GLENN BUFFALO
Buffalo
County/Group: Wright County

Inspection Info

Report Number: F7930261274
Inspection Type: Full
Date: 9/8/2026
Time: 11:16:40 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 166.7 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL20395016-0	**Date:** September 10, 2026
Facility Name: GLENN BUFFALO	
Facility Address: 201 1ST STREET NE BUFFALO, MN 55313	

☒ **TAG IDENTIFICATION: 0775**

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

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Compressed gas containers, cylinders and tanks shall be secured to prevent falling caused by contact, vibration or seismic activity. [Minn. Stat. 144G.45 subd. 2; MSFC 5303.5.3]

   Comments: Loose oxygen tanks were observed in unit 210.

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: Units 268 and 180 only had audible notification devices in the living room area. No audible notification device was present in the sleeping rooms.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The 2nd level laundry room had plumbing that was temporarily capped. A permanent cap should be installed.

   Unit 108 was heavily soiled and access to all areas of the resident unit was restricted by the items throughout the unit. The items reduced or obstructed the path of egress from each space and the apartment which could impeded safe evacuation during an emergency.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: No documentation was provided that indicated resident training was offered.