



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 10, 2026

Licensee

Butterfly Assisted Living LLC

12 98th Lane Northwest

Coon Rapids, MN 55448

RE: Project Number(s) SL39271016

Dear Licensee:

On December 9, 2025, the Minnesota Department of Health completed a follow-up survey of your to determine correction of orders from the facility completed on . This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kelly Thorson'.

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

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August 25, 2025

Licensee

Butterfly Assisted Living LLC

12 98th Lane Northwest

Coon Rapids, MN 55448

RE: Project Number(s) SL39271016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 1, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 3: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

St - 0 - 0495 - 144g.41 Subdivision. 1 (13) - Minimum Requirements - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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>

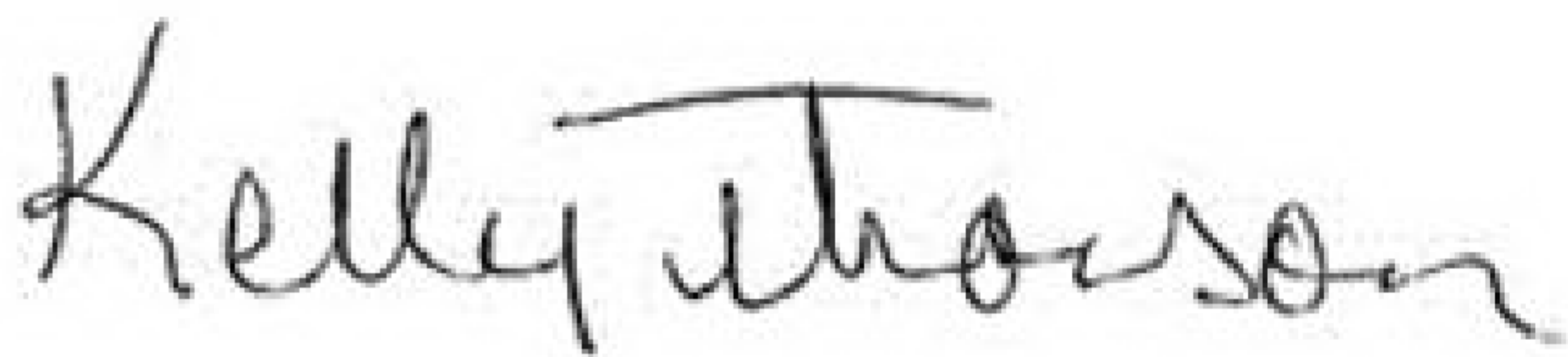
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

A handwritten signature in black ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39271	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER BUTTERFLY ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12 98TH LANE NORTHWEST COON RAPIDS, MN 55448		
(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: SL39271016-0 On June 23, 2025, through July 1, 2025, 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 three residents; all of whom are receiving services under the Assisted Living Facility license. An immediate correction order was identified on June 26, 2025, issued for SL39271016, tag identification 0495. During the course of the survey, the licensee failed to take action to mitigate the imminent risk identified in the immediate order.	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			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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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, June 24, 2025, 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	0 480			
	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.				
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 23, 2025, at 10:58 a.m., during the entrance conference, owner/licensed assisted living director (O/LALD)-A stated clinical nurse supervisor (CNS)-B was the only registered nurse (RN) employed by the licensee at the time of the survey. O/LALD-A stated CNS-B worked another RN position at a hospital in St. Paul, MN. O/LALD-A stated CNS-B was able to be reached by text or phone call when needed. O/LALD-A stated the licensee considered hiring an	0 495			

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0 495	Continued From page 4 additional nurse to assist the licensee when CNS-B was unavailable but had not done so yet. O/LALD-A stated the expected return time frame was one hour for CNS-B to return a phone call from licensee. On June 23, 2025, at 3:46 p.m., CNS-B stated they worked 40 hours per week at a nursing home as an RN Case Manager. CNS-B stated they have instructed staff to call or text CNS-B with any needs related to resident condition or care. CNS-B stated they are the only RN employed with the licensee since time of hire, March 7, 2023. CNS-B stated that a conversation was had with LALD-A regarding the need to hire another RN to assist with nursing coverage for the licensee but that had not occurred yet. On June 24, 2025, at 1:04 p.m., surveyor emailed CNS-B to schedule an interview regarding survey findings. On June 24, 2025, at 2:08 p.m., CNS-B emailed the surveyor, "I will give you a call." On June 24, 2025, at 3:38 p.m., CNS-B called the surveyor however, there was no response when answered by the surveyor. On June 24, 2025, at 4:03 p.m., surveyor emailed CNS-B to schedule interview call on June 25, 2025. On June 25, 2025, at 7:23 a.m., CNS-B emailed surveyor with proposed time of 11:30 a.m. for interview call. Surveyor acknowledged and agreed to proposed time via email at 7:36 a.m. No call was received by CNS at the scheduled time.	0 495			

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0 495	Continued From page 5 On June 25, 2025, at 11:46 a.m., CNS-B emailed surveyor with proposed time of 2:30 p.m., for CNS-B to call surveyor for interview. Surveyor acknowledged and agreed to proposed time via email at 11:50 a.m. On June 25, 2025, at 2:48 p.m., CNS-B called surveyor and completed interview questions as well as reviewed documents needing to be provided for review. On June 25, 2025, at 4:26 p.m. and 4:28 p.m., surveyor emailed CNS-B documents needed for review as discussed during the interview phone call that concluded at 3:47 p.m., with a timeline to be provided by 10:00 p.m. on the same day. At 4:36 p.m., CNS-B emailed a response that read, "I will be working on this and will send in as soon as possible, but definitely not everything at 10 o'clock this evening." On June 26, 2025, at 12:46 p.m., owner/licensed assisted living director (O/LALD)-A emailed surveyor the following, "Many of the requested items-such as assessments, medication orders, and clinical competencies-require the direct involvement of our licensed nurse [sic], who is employed part-time off-site and does not have availability during regular business hours. She [sic] is scheduled to be off work from her [sic] other full-time job after 5:00 p.m. today, at which point she [sic] will be able to assist us in retrieving and preparing these records accurately and in full compliance. We were first informed of these follow-up requirements yesterday evening and again this morning. To be expected to produce such a large volume of critical records-some of which involve secure system access, clinical review, and cross-referencing-in less than 24 hours is simply not feasible for a small residential	0 495			

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0 495	Continued From page 6 facility operating with limited administrative capacity during the day." The licensee's Staffing policy, dated July 20, 2022, indicated "The Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R1). This practice resulted in a level two violation (a	0 630			

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0 630	Continued From page 7 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 and began receiving assisted living services on October 3, 2024. R1's record included a Resident Contract for Assisted Living signed by R1 on October 3, 2024. R1's diagnoses included: anxiety, depression, diabetes, and chronic chronic obstructive pulmonary disorder (lung disease causing breathing difficulty). R1's record lacked an individualized review or assessment of the resident's risk of abusing other vulnerable adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On June 23, 2025, at 5:09 p.m., owner/licensed assisted living director (O/LALD)-A stated an individual abuse prevention plan (IAPP) must be completed for each resident after moving into the licensee's facility. In addition, O/LALD-A state R1's risk to abuse others was missed in error because of the extra information that was included regarding R1's mental health concerns. The licensee's Vulnerable Adult Policy dated July	0 630			

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0 630	Continued From page 8 20, 2022, indicated, an individual abuse prevention plan shall be established for each vulnerable minor or adult for whom assisted living services are provided. 1) The plan shall contain an individualized assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults 2) The plan shall contain the resident's risk of abusing other vulnerable adults 3) The plan shall contain statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. 4) The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. 5) Documentation will include results of the implementation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
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 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;	0 680			

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0 680	Continued From page 9 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 plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors of 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 of the residents). The findings include: The licensee's EPP dated February 1, 2025, lacked the following content and/or policies and procedures to address: - quarterly review of missing resident policy; - development of policy/procedure to address emergency staffing strategies including surge	0 680			

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0 680	Continued From page 10 planning and use of volunteers; and - must conduct exercises to test the EPP at least twice per year. On June 25, 2025, at 9:49 a.m., owner/licensed assisted living director (O/LALD)-A stated they were aware of how to report when a resident was missing, however did not know it was required the missing resident policy be reviewed quarterly. O/LALD-A further stated the licensee did not use volunteers and only fire drills had been completed due to not being aware of the requirement of two disaster drills per year in addition to the fire drills. The licensee's Emergency Preparedness policy dated July 20, 2022, did not address use of volunteers or quarterly review of the missing resident policy. The policy indicated the licensee conducted a disaster drill at the residence at least annually and results would be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 810	Continued From page 11	0 810			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique 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:	0 810			

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0 810	Continued From page 12 Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on June 23, 2025, from 1:30 p.m. to 3:30 p.m., the surveyor toured the facility license assisted living director (LALD)-A., surveyor observed resident room numbers was not identified on the facility floor plan. Fire evacuation diagrams posted throughout the facility incorrectly showed identification of the path of egress by leading individuals to unapproved exits. Exit plan diagrams and resident bedrooms must be correctly labeled to reduce confusion and potential obstructions for egress in a fire or similar emergency. June 23, 2025, from 1:30 p.m. to 3:30 p.m., with LALD-A; provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated July 20, 2022, failed to include the following:	0 810			

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0 810	Continued From page 13 STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use/access or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On June 23, 2025, at 2:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to	0 810			

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0 810	Continued From page 14 employees on the FSEP upon hire and at least twice per year. LALD-A stated staff does web-based training at the time of hire. No other training documentation was provided. On June 23, 2025, at 2:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060			

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01060	Continued From page 15 resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01060			

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01060	Continued From page 16 R1 was admitted to the licensee and began receiving assisted living services on October 3, 2024. R1's records included a progress note dated March 9, 2025, that indicated R1 was brought to the emergency room and admitted to the hospital. R1's records also included a progress note dated March 11, 2025, that indicated R1 was discharged from the hospital and returned to the licensee. R1's records included a progress note dated June 16, 2025, that indicated R1 was brought to the emergency room and admitted to the hospital. R1's records also included a progress note dated June 19, 2025, that indicated R1 was discharged from the hospital and returned to the licensee. R1's record lacked a written notice with the required statutory content provided to the resident or resident representative for either of the emergency relocations. On June 24, 2025, at 1:16 p.m., owner/licensed assisted living director (O/LALD)-A stated a progress note or incident report form is completed when a resident goes to the hospital. O/LALD-A further stated they were unaware of the requirement to complete an emergency relocation form with required content. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370			

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01370	Continued From page 17 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370			

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01370	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of two employees (unlicensed personnel (ULP)-C and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on March 1, 2023, to provide direct care services to residents. ULP-C's employee record included orientation training, however, lacked training for modified diets. ULP-E ULP-E was hired on February 10, 2023, to provide direct care services to residents. ULP-E's employee record included orientation training, however, lacked training for modified diets. On June 24, 2025, at 8:00 a.m., the surveyor observed ULP-E providing assistance with	01370			

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01370	Continued From page 19 morning activities of daily living (ADL) for R3. On June 25, 2025, at 3:33 p.m., clinical nurse supervisor (CNS)-B stated training for the new modified diet order received by R1 was provided for ULP-C and ULP-E on the day R1 returned from the hospital. CNS-B further stated all other facility staff would be trained and documentation completed on June 25, 2025. The licensee's Staff Orientation and Education policy, dated July 20, 2022, indicated, "All staff providing assisted living through Butterfly Assisted Living, LLC will be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents." The licensee's Personnel Records policy, dated July 20, 2022, indicated, "At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements - Evidence of current professional licensure, registration or certification - Results of background studies - Records of annual training and infection control training - Documentation of orientation - Documentation of supervision, as applicable - Performance reviews - Competency evaluations - Signed job description - Documentation of annual performance reviews identifying areas of improvement needed and training needs." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01370			

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01370	Continued From page 20 (21) days	01370			
01500 SS=F	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 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),	01500			

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01500	Continued From page 21 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 all employees who performed direct services completed all required training components for each twelve months of employment for two of two employees (unlicensed personnel (ULP)-C and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	01500			

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01500	Continued From page 22 ULP-C ULP-C was hired on March 1, 2023, to provide direct care services to residents. ULP-C's employee record lacked annual training for the following required topics for 2024: - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider policies and procedures; and - the principles of person-centered planning and service delivery. ULP-E ULP-E was hired on February 10, 2023, to provide direct care services to residents. ULP-E's employee record lacked annual training for the following required topics for 2024: - reporting of maltreatment of vulnerable adults; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques; - effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider policies and procedures; and - the principles of person-centered planning and service delivery. On July 1, 2025, at 9:28 a.m., owner/ licensed	01500			

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01500	Continued From page 23 assisted living director (O/LALD)-A stated annual education for all employees was completed throughout each calendar year and was facilitated by O/LALD-A in 2024. Furthermore, O/LALD-A stated documentation from Educare (electronic education software) was not available due to difficulty with using the program. The licensee's Staff Orientation and Education policy dated July 20, 2022, indicated "All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment." In addition, the policy indicated the above topics were part of required annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530			

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01530	Continued From page 24 (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least two hours of dementia care training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-C and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01530			

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NAME OF PROVIDER OR SUPPLIER BUTTERFLY ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12 98TH LANE NORTHWEST COON RAPIDS, MN 55448		
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01530	Continued From page 25 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: ULP-C ULP-C was hired on March 1, 2023, to provide direct care services to residents. ULP-E ULP-E was hired on February 10, 2023, to provide direct care services to residents. On June 24, 2025, at 8:00 a.m., surveyor observed ULP-E providing assistance with morning activities of daily living (ADL) for R3. ULP-C and ULP-E's records lacked evidence each ULP completed two (2) hours of annual dementia care training. On July 1, 2025, at 9:28 a.m., owner/ licensed assisted living director (O/LALD)-A stated annual education for all employees is completed throughout each calendar year and was facilitated by O/LALD-A in 2024. Furthermore, O/LALD-A stated documentation from Educare (electronic education software) was not available due to difficulty with using the program. The licensee's Dementia Education policy dated July 20, 2022, indicated, "Direct care employees will complete at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01530			

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01530	Continued From page 26 (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620			

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01620	Continued From page 27 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. (f) 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for three of three residents (R1, R2, 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 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 June 23, 2025, at 3:52 p.m., clinical nurse supervisor (CNS)-B stated the licensee completed a preadmission assessment, admission assessment, 14-day assessment, 90-day assessments, and change of condition assessments.	01620			

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01620	Continued From page 28 R1 R1 was admitted to the licensee and began receiving assisted living services on October 3, 2024. R1's Service Plan (Waiver) - Addendum to Contract signed October 3, 2024, indicated R1 received assistance with diabetic management, medication management, vital signs, dressing, housekeeping, laundry, meals, and shopping. R1's record included a 14-day assessment completed on October 16, 2024, and clinical update assessments completed on April 15, 2025, and June 19, 2025. R1's record indicated 181 days had passed between R1's 14-day assessment and the next comprehensive clinical assessment. R2 R2 was admitted to the licensee and began receiving assisted living services on December 2, 2023. R2's Service Plan (Waiver)- Addendum to Contract signed on December 2, 2023, indicated R2 received assistance with medication management, behavior management, dressing, housekeeping, laundry, meals, and shopping. R2's record included ongoing 90-day assessments completed on June 8, 2024, October 16, 2024, and a clinical update assessment completed on April 20, 2025. R2's record indicated 130 days and 186 days, respectively, had passed between assessments. Furthermore, R2's record indicated the assessment completed on June 8, 2024, was completed by licensed assisted living director	01620			

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01620	Continued From page 29 (LALD)-A, and not by a RN as required. R3 R3 was admitted to the licensee and began receiving assisted living services on August 1, 2023. R3's Service Plan (Waiver)- Addendum to Contract signed on August 14, 2023, indicated R3 received assistance with glucose monitoring, medication management, behavior management, vital signs, dressing, housekeeping, laundry, meals, and shopping. R3's record included a 90-day assessment completed on May 30, 2024, and clinical update assessments completed on August 28, 2024, and June 19, 2025. R3's record indicated 295 days passed between the two most recent assessments. Furthermore, R3's record indicated the assessment completed on May 30, 2024, was completed by LALD-A, and not by a RN as required. On June 25, 2025, at 3:14 p.m., CNS-B stated ongoing resident assessment are due at least every 90-days and can be completed by the administrator or RN. Furthermore, CNS-B stated assessments were late because CNS-B may have selected a 180-day reminder in RTasks (electronic medical record software) instead of a 90-day reminder. The licensee's Assessment and Reassessment policy dated July 20, 2022, indicated, "Ongoing resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment." No further information was provided.	01620			

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01620	Continued From page 30	01620			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN)	01700			

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01700	Continued From page 31 conducted an assessment to determine what medication management services would be provided, and how the medication services would be provided 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 and began receiving assisted living services on October 3, 2024. On June 24, 2025, at 9:50 a.m., surveyor observed R1 self-administer R1's Breo Ellipta inhaler (reduces swelling in lungs and relaxes airway muscles) and Spiriva inhaler (airway muscle relaxant). The surveyor then observed unlicensed personnel (ULP)-E administer scheduled medications to R1. R1's Service Plan (Waiver) - Addendum to Contract signed October 3, 2024, indicated R1 received assistance with diabetic management, medication management, vital signs, dressing, housekeeping, laundry, meals, and shopping. R1's record lacked a medication assessment that included review of all medications and evidence of assessment of R1's ability to safely self-administer the following: Breo Ellipta inhaler, Spiriva inhaler, and calcium carbonate tablets (gastric acid reducer).	01700			

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01700	Continued From page 32 On June 25, 2025, at 3:07 p.m., clinical nurse supervisor (CNS)-B stated individual medication management plans were completed for each resident. Furthermore, CNS-B stated if a medication would be self-administered, the resident was asked to demonstrate competency to safely administer the medication and an order for self-administration would be requested from the resident's doctor. The licensee's undated Medication Management Program policy, indicated, "Admission to the Medication Management Program is at the discretion of the Registered Nurse and based on a professional face-to-face nursing assessment that includes the following elements. 1. Resident, resident's designated representative and/or resident's legal representative ability in medication self-management." The policy further indicated medication reconciliation was included in the medication management program. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	01730			

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01730	Continued From page 33 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for	01730			

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01730	Continued From page 34 each resident to include all required content for three of three residents (R1, R2, and 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents) The findings include: R1 R1 was admitted to the licensee and began receiving assisted living services on October 3, 2024. R1's diagnoses included diabetes, anxiety, depression, COPD (chronic obstructive pulmonary disease defined as swelling and irritation of the lungs causing difficulty breathing). R1's Service Plan (Waiver) - Addendum to Contract signed October 3, 2024, indicated R1 received assistance with diabetic management, medication management, vital signs, dressing, housekeeping, laundry, meals, and shopping. R1's Individualized Medication Management Plan dated June 19, 2025, lacked documentation of the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications;	01730			

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01730	Continued From page 35 - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R2 R2 was admitted to the licensee and began receiving assisted living services on December 2, 2023. R2's diagnoses included paranoid schizophrenia (person experiences hallucinations and paranoid and delusional thoughts), obsessive compulsive disorder (person experiences persistent and unwanted thoughts and/or repetitive behaviors), and hypertension (high blood pressure). R2's Service Plan (Waiver)- Addendum to Contract signed on December 2, 2023, indicated R2 received assistance with medication management, behavior management, dressing, housekeeping, laundry, meals, and shopping. R2's Individualized Medication Management Plan dated April 20, 2025, lacked documentation of the following: - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when	01730			

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01730	Continued From page 36 a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. R3 R3 was admitted to the licensee and began receiving assisted living services on August 1, 2023. R3's diagnoses included hypertension and diabetes. R3's Service Plan (Waiver)- Addendum to Contract signed on August 14, 2023, indicated R3 received assistance with glucose monitoring, medication management, behavior management, vital signs, dressing, housekeeping, laundry, meals, and shopping. R3's Individualized Medication Management Plan dated June 19, 2025, lacked documentation of the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration,	01730			

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01730	Continued From page 37 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On June 25, 2025, at 3:07 p.m., clinical nurse supervisor (CNS)-B stated medication management plans were created for each resident and consisted of reviewing medications ordered and how the licensee managed them. CNS-B further stated they were unaware there was specific required content for each medication management plan. The licensee's undated Medication Management Program policy indicated, "The following services are included in the Medication Management Program. 1. Performing medication setup 2. Administering medications 3. Storing and securing medications 4. Documenting medication activities 5. Verifying and monitoring the effectiveness of systems to ensure safe handling and administration 6. Coordinating refills 7. Handling and implementing changes to prescriptions 8. Communicating with the pharmacy about the resident's medications 9. Coordinating and communicating with the prescriber." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			

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01750	Continued From page 38	01750			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for medication administration for two of two residents (R1 and 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, 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: On June 24, 2025, at 9:21 a.m., the surveyor observed unlicensed personnel (ULP)-E administer scheduled medication to R1.	01750			

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NAME OF PROVIDER OR SUPPLIER BUTTERFLY ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12 98TH LANE NORTHWEST COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 39 R1 R1 was admitted to the licensee and began receiving assisted living services on October 3, 2024. R1's diagnoses included diabetes, anxiety, depression, COPD (chronic obstructive pulmonary disease defined as swelling and irritation of the lungs causing difficulty breathing). R1's Service Plan (Waiver) - Addendum to Contract signed October 3, 2024, indicated R1 received assistance with diabetic management, medication management, vital signs, dressing, housekeeping, laundry, meals, and shopping. R1's Med (Medication) Admin (Administration) Summary - Month dated June 1, 2025, through June 30, 2025, included the following medications and the medication administration record (MAR) read: -Breo Ellipta (daily) **Self Admin** 100-25 micrograms (mcg)/ dose inhale one puff by mouth once daily. Doctor's comments: rinse mouth after each use. Discard six weeks after opening or when the counter reads *0* (after all blisters have been used) whichever comes first; -Buproban 150 milligrams (mg) take one tablet by mouth every morning; -cetirizine 10 mg take one tablet by mouth daily; -citalopram 20 mg take one tablet daily by mouth; -gabapentin 100 mg take one capsule by mouth in the morning, take one capsule in the afternoon, and take one capsule every evening; -insulin aspart 70/30 inject 14 units subcutaneous two times daily before meals; and -Spiriva Respimat 2.5 mcg/actuation inhale two puffs by mouth once daily. R1's medication administration record (MAR)	01750			

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01750	Continued From page 40 lacked specific pill identifiers for the ULP to complete rights of medication administration following medication set-up by the RN. R3 R3 was admitted to the licensee and began receiving assisted living services on August 1, 2023. R3's diagnoses included hypertension and diabetes. R3's Service Plan (Waiver)- Addendum to Contract signed on August 14, 2023, indicated R3 received assistance with glucose monitoring, medication management, behavior management, vital signs, dressing, housekeeping, laundry, meals, and shopping. R3's Med Admin Summary - Month dated June 1, 2025, through June 30, 2025, included the following medications and the MAR read: - aspirin 81 mg chew one tablet daily; - atorvastatin 20 mg take one tablet by mouth every morning; - lisinopril 20 mg take one tablet by mouth daily; - metformin 500 mg take four tablets (2,000 mg) by mouth once daily; - amlodipine 10 mg take one tablet by mouth once daily; - chlorthalidone 25 mg take one tablet by mouth once daily; - Jardiance 10 mg take one tablet by mouth once daily; and - chlorhexidine gluconate 0.12% solution rinse with 15 milliliters (ml) twice a day in the morning and at night and spit do not swallow. R3's MAR lacked specific pill identifiers for the ULP to complete rights of medication	01750			

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01750	Continued From page 41 administration following medication set-up by the RN. On June 25, 2025, at 3:21 p.m., clinical nurse supervisor (CNS)-B stated ULP were familiar with residents' medications due to having become comfortable with few residents. CNS-B further stated ULPs were trained to look at the medication bottles available in the med cart for pill identifiers. The licensee's Medication Administration policy dated July 20, 2022, indicated, all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate f. Side effects g. Resident allergies to medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date	01760			

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01760	Continued From page 42 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 and record review, the licensee failed to administer medications according to provider orders for one of one resident (R2). 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 June 24, 2025, at 7:30 a.m., while accompanied by unlicensed personnel (ULP)-D, surveyor observed four cards of lorazepam (anti-anxiety medication) 1 milligram (mg) that belonged to R2. All four cards of lorazepam had pharmacy labels that indicated the medication was prescribed with instructions, "take one (1) tablet by mouth up to twice a day as needed for anxiety or insomnia." R2's medication administration record (MAR), dated May 2025, indicated the following	01760			

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01760	Continued From page 43 instructions: Lorazepam (daily) give 1 mg tab by mouth once a day. R2 received 31 doses according to MAR instructions and not as needed (PRN) doses as prescribed during the month of May. Additionally, R2's June 2025 MAR instructed staff to administer: Lorazepam (daily) give 1 mg tab by mouth once a day. R2 received 24 doses according to MAR instructions and no PRN doses during the month of June. R2's prescriber orders signed on December 12, 2023, indicated lorazepam 1 mg, take one tablet by mouth up to twice a day PRN for anxiety or insomnia. The licensee's Medication Orders policy dated July 20, 2022, indicated, "Butterfly Assisted Living, LLC will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of four	01830			

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01830	Continued From page 44 residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 23, 2025, at 11:10 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management to residents at the facility. R2 was admitted to the licensee and began receiving assisted living services on December 2, 2023. R2's diagnoses included paranoid schizophrenia (person experiences hallucinations and paranoid and delusional thoughts), obsessive compulsive disorder (person experiences persistent and unwanted thoughts and/or repetitive behaviors), and hypertension (high blood pressure). R2's Service Plan (Waiver)- Addendum to Contract signed on December 2, 2023, indicated R2 received assistance with medication management, behavior management, dressing, housekeeping, laundry, meals, and shopping. On June 24, 2025, at 7:30 a.m., surveyor observed R2's medication supply to contain 30 tablets of lorazepam one milligram (mg) which	01830			

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01830	Continued From page 45 expired on December 7, 2024. R2's prescriber order, dated December 12, 2023, included an order for lorazepam 1 mg, take one tablet by mouth up to twice a day as needed for anxiety or insomnia. R2's record lacked evidence of a current prescription, as required. R2's Med (medication) Admin (administration) Summary- Month, dated June 2025, indicated R2 received lorazepam one mg at 5:00 p.m., on June 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23, respectively. On June 26, 2025, at 8:46 p.m., clinical nurse supervisor (CNS)-B sent an email (electronic mail) which indicated requested documentation was provided. The licensee's Medication Orders policy dated July 20, 2022, indicated, medication orders will be renewed at least every 12 months or as required by the physician, the RN assessment and/or regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
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	01880			

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01880	Continued From page 46 by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access, and the licensee failed to ensure prescription medications were stored according to the manufacturer's directions 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) 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: MEDICATION STORAGE On June 24, 2025, at 7:56 a.m., the surveyor observed the main kitchen refrigerator with unlicensed personnel (ULP)-E. The refrigerator contained 12 insulin pens for R1 that were stored on the top shelf and unsecured within the refrigerator. The refrigerator also lacked a locking mechanism. MANUFACTURER'S DIRECTIONS On June 24, 2025, at 7:56 a.m., surveyor observed the licensee's main kitchen refrigerator which contained medication that belonged to R1. The refrigerator lacked a working thermometer to indicate the internal temperature of the refrigerator, and the surveyor observed R1's 12 NovoLog Mix 70/30 insulin pens. The manufacturer's instructions for NovoLog Mix 70/30 insulin pen dated February 2023	01880			

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01880	Continued From page 47 recommended unused insulin pens be stored in a refrigerator with the temperature range set between 36-46 degrees Fahrenheit (F). Do not freeze insulin pens and if frozen discard insulin pens. On June 24, 2025, at 7:58 a.m., ULP-E stated ULP-E was unsure how long the thermometer was not working, and daily temperature was not recorded. ULP-E further stated the refrigerator's temperature was monitored by cold level indicator lights on the exterior refrigerator display. On June 25, 2025, at 2:49 p.m., clinical nurse supervisor (CNS)-B stated staff were trained to monitor the refrigerator temperature every shift and record. CNS-B further stated CNS-B was unaware the thermometer was not working. On June 25, 2025, at 2:51 p.m., CNS-B stated that medications stored in the main refrigerator must be stored in a locked compartment within. The licensee's Storage/Control of Medications policy dated July 20, 2022, indicated, "Medications are stored in a secured medication cabinet. Only authorized nursing personnel have access to the locked cabinet." The policy further indicated, "Medications requiring refrigeration are clearly labeled and stored in an enclosed container or area separated from foods. Temperature is maintained at 35-40 degrees." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			

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01890	Continued From page 48	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 monitor for expired medications for one of three residents (R2). 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 June 24, 2025, at 7:34 a.m., surveyor, along with unlicensed personnel (ULP)-D, observed R2's medication supply contained in the main medication storage cart. Surveyor located a medication card belonging to R2 that contained 30 tablets of lorazepam one milligram (mg) which had a 'use by' date on the pharmacy label of December 7, 2024. R2's record included signed provider orders dated December 12, 2023, that included an order for lorazepam one mg take one tablet up to twice	01890			

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01890	Continued From page 49 daily as needed for anxiety or insomnia. R2's record included R2's Med Admin Summary - Month dated June 1, 2025, through June 30, 2025, which indicated R2 received lorazepam one mg daily, on a scheduled basis. On June 25, 2025, at 3:02 p.m., clinical nurse supervisor (CNS)-B stated CNS-B completed medication supply audits every Sunday to look for expired medications and assure medications were labeled appropriately. CNS-B further stated all staff were trained to look for expiration dates prior to medication administration. The licensee's Medication Administration policy dated July 20, 2022, indicated, The licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	01940			

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01940	Continued From page 50 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation 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) who had treatments or therapies managed by the licensee. 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	01940			

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01940	Continued From page 51 situation has occurred only occasionally). The findings include: R1 was admitted to the licensee and began receiving assisted living services on October 3, 2024. R1's diagnoses included diabetes, anxiety, depression, COPD (chronic obstructive pulmonary disease defined as swelling and irritation of the lungs causing difficulty breathing). R1's prescriber orders dated January 24, 2025, included an order to check blood sugar daily. R1's Assessment dated June 26, 2025, indicated R1 received assistance with applying and removing compression stockings daily. R1's Vital Sign - Blood Glucose dated June 1, 2025, through June 26, 2025, indicated R1 received blood glucose testing on June 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 19, 20, 21, 22, 23, 24, 25, and 26. On June 24, 2025, at 9:50 a.m., the surveyor observed unlicensed personnel (ULP)-E complete scheduled blood glucose check and applied compression stockings for R1. R1's record lacked evidence of an individualized treatment or therapy management plan which included the following: - 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	01940			

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01940	Continued From page 52 services. The licensee's Comprehensive Nursing Assessment policy, dated July 20, 2022, indicated a registered nurse completed an assessment which included current treatments the resident requires, including the type, frequency and level of assistance needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded orders were obtained for one of one resident (R1) with treatments. 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	01970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39271	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER BUTTERFLY ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 12 98TH LANE NORTHWEST COON RAPIDS, MN 55448		
(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
01970	Continued From page 53 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 and began receiving assisted living services on October 3, 2024. R1's diagnoses included diabetes, anxiety, depression, COPD (chronic obstructive pulmonary disease defined as swelling and irritation of the lungs causing difficulty breathing). R1's record included a Service Plan (Waiver) - Addendum to Contract signed October 3, 2024, which indicated R1 received assistance with diabetic management, medication management, vital signs, dressing, housekeeping, laundry, meals, and shopping. R1's record included a Service Recap Summary - Month, dated June 2025, which indicated compression stocking services were provided daily, AM (morning) and PM (evening). R1's record lacked a treatment plan. On June 24, 2025, at 9:50 a.m., the surveyor observed unlicensed personnel (ULP)-E apply compression stockings for R1. R1's provider orders dated April 16, 2025, lacked an order for compression stockings. On June 25, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-B stated a provider order was required for treatments to be administered. R1's order was missed. The licensee's Prescriber's Orders policy dated	01970			

Minnesota Department of Health

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01970	Continued From page 54 July 20, 2022, indicated, "Written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-E) observed administering medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39271	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/01/2025
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02320	Continued From page 55 a large portion or all of the residents). The findings include: ULP-E was hired on February 10, 2023, to provide services, including medication administration, to the licensee's residents. ULP-E completed medication administration training on August 30, 2023, and demonstrated competency to a registered nurse (RN) on September 10, 2023. On June 24, 2025, at 9:21 a.m., the surveyor observed ULP-E conduct a scheduled morning medication pass for R1. ULP-E removed R1's pill bar from the medication cart and dispensed the oral medications in a medication cup, obtained R1's unlabeled and undated insulin pen and needle for administration, and ULP-E walked to the stairwell to bring R1's medications to R1's room for administration. The surveyor then stopped ULP-E and inquired how ULP-E completed rights of medication administration for R1. ULP-E then logged into RTasks (electronic medical record software) and identified R1 had four medications ordered and pointed to four medications in the medication cup. ULP-E did not locate R1's insulin on the medication administration record (MAR) and called clinical nurse supervisor (CNS)-B for guidance. ULP-E then administered the scheduled medications as ordered. On June 24, 2025, at 9:27 a.m., ULP-E stated ULP-E was familiar with R1 and the medications R1 takes daily due R1s longevity living at licensee and medications changed rarely. ULP-E further stated, "[ULP-E] look for the resident's name, check the phone (pointing to R1's eMAR), and	02320			

Minnesota Department of Health

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02320	Continued From page 56 can look at the bottles if [ULP-E] unsure of the medication." On June 25, 2025, at 2:56 p.m., CNS-B stated staff were trained to keep controlled medications double-locked and to verify controlled medication counts at each change of shift. On June 25, 2025, at 3:21 p.m., CNS-B stated during training, ULPs were taught to complete the rights of medication administration and to look at the bottle for each medication scheduled and identify markers of each pill or colors. CNS-B further stated staff were familiar with residents due to having so few and become comfortable with the medications they give daily. The licensee's Medication Administration policy dated July 20, 2022, indicated, "Residents of Butterfly Assisted Living, LLC are entitled to the safe administration of medications by qualified personnel according to a written Medication Management Plan." In addition, the policy indicated, "The Registered Nurse may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol. a. All home health aides have passed a competency evaluation with respect to all medication routes to be administered b. The Registered Nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident c. The Registered Nurse has communicated with/provided orientation to the home health aide regarding the individual needs of the resident."	02320			

Minnesota Department of Health

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02320	Continued From page 57 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 23, 2025, at 11:44 a.m., during a tour of the facility with the owner/licensed assisted living	03090			

Minnesota Department of Health

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03090	Continued From page 58 director (O/LALD)-A, a sign posted which indicated, "NOTICE This Area is under 24 hours video surveillance," was observed above the stairway, just inside the front door. On June 24, 2025, at 12:04 p.m., O/LALD-A stated O/LALD-A was aware a notice of electronic monitoring was required however O/LALD-A was unaware there was specific verbiage that was required. The licensee's Electronic Monitoring policy dated July 20, 2022, indicated, "Butterfly Assisted Living, LLC will post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities"." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Butterfly Assisted Living LLC
12 98th Lane NW
Coon Rapids, MN 55448
Anoka County
Parcel:

Phone: 763-264-6067
butterflyhome2022@gmail.com

License Info

License: 0039271
29188

SAID ALI
Risk:
License: -1
Expires on:
CFPM: SAID ALI
CFPM #: 113663; Exp: 9/28/2025

Inspection Info

Report Number: F1029251085
Inspection Type: Follow-up - Single
Date: 7/1/2025 Time: 9:45:44 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

ESTABLISHMENT CLEARED ALL PREVIOUSLY ISSUED CORRECTION ORDERS.

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 Metro District Office inspection report number F1029251085 from 7/1/2025

SAID ALI
LALD

Trevor McCliment

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Butterfly Assisted Living LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1029251085
Inspection Type: Follow-up
Date: 7/1/2025
Time: 9:45:44 AM

Equipment Temperature: Product/Item/Unit: COOLER INTERNAL THERMOMETER; Temperature Process: COLD HOLDING

Location: COOLER at 39 Degrees F.

Comment:

Violation Issued?: No

New Record: Product/Item/Unit: FREEZER INTERNAL THERMOMETER; Temperature Process: FREEZING

Location: FREEZER at -17 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Butterfly Assisted Living LLC
Coon Rapids
County/Group: Anoka County

Inspection Info

Report Number: F1029251085
Inspection Type: Follow-up
Date: 7/1/2025
Time: 9:45:44 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Butterfly Assisted Living LLC
12 98th Lane NW
Coon Rapids, MN 55448
Anoka County
Parcel:

Phone: 763-264-6067
butterflyhome2022@gmail.com

License Info

License: 0039271
29188

SAID ALI
Risk:
License: -1
Expires on:
CFPM: HASSAN A. ALI
CFPM #: FM113663; Exp: 9/8/2025

Inspection Info

Report Number: F1029251045
Inspection Type: Full - Single
Date: 6/24/2025 Time: 2:30:41 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 5
Total Priority 2 Orders: 5
Total Priority 3 Orders: 6
Delivery:

New Order: 2-100 Supervision

2-102.11D,E,F,G,H,I Priority Level: Priority 2 CFP#: 1

MN Rule 4626.0030DEFGHI The person in charge must be able to demonstrate their knowledge to the inspector of the importance of the following food handling procedures to preventing foodborne disease: handwashing; avoiding cross contamination; avoiding hand contact with ready-to-eat foods; time and temperature requirements for safely refrigerating, hot holding, cooling, and reheating TCS food; hazards of eating raw or undercooked meat, poultry, eggs, and fish; food temperatures and cooking times required to safely cook TCS food including meat, poultry, eggs, and fish; foods identified as major food allergens and the symptoms of an allergic reaction; identification of critical control points in a food service operation and steps to be taken to ensure the points are controlled.

COMMENT: PERSON IN CHARGE (PIC) AND HOUSE MANAGER UNAWARE OF SAFE COOKING TEMPERATURES FOR RAW ANIMAL PROTEINS OR SAFE COLD HOLDING TEMPERATURES FOR TCS FOODS. SAFE COOKING AND HOLDING TEMPERATURES REVIEWED.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

New Order: 2-100 Supervision

2-102.12DMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033D Post the certified food protection manager certificate.

COMMENT: CFPM CERTIFICATE NOT POSTED. OPERATOR INSTRUCTED TO POST CERTIFICATE.

Comply By: 6/27/2025 Originally Issued On: 6/24/2025

New Order: 2-100 Supervision

2-102.12FMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033F The certified food protection manager must identify the hazards in the operation of the food establishment; develop or implement policies, procedures, or standards to prevent foodborne illness in the food establishment; coordinate training, supervision or direction of food preparation activities; take corrective action in the food establishment as needed to protect the health of the consumer; and, complete in-house self-inspections of the daily operations in the food establishment at a frequency that ensures food safety policies and procedures are followed.

COMMENT: PIC INDICATED CFPM IS AT ESTABLISHMENT ONLY ONCE PER WEEK. LACK OF FOOD SAFETY KNOWLEDGE AND OTHER FOOD HAZARDS IDENTIFIED DURING INSPECTION. THE CFPM MUST PROVIDE ADEQUATE TRAINING TO STAFF AND ENSURE ENOUGH OF AN ONSITE PRESENCE TO PREVENT TEMPERATURE ABUSE, CONTAMINATION, AND OTHER POTENTIAL FOOD AND BEVERAGE HAZARDS.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

New Order: 2-100 Supervision2-103.11LN *Priority Level: Priority 2 CFP#: 1*

MN Rule 4626.0035LN The person in charge must ensure employees: inform consumers that clean tableware must be used when returning to self-service food areas such as salad bars and buffets; are properly trained in food safety, including food allergy awareness; and are trained to perform food preparation activities in an approved location.

COMMENT: FOOD SAFETY KNOWLEDGE NOT EFFECTIVELY DISSEMINATED TO ALL INDIVIDUALS INVOLVED IN FOOD AND BEVERAGE OPERATION. OPERATOR INSTRUCTED TO WORK WITH CFPM TO ENSURE FOOD SAFETY KNOWLEDGE IS SUCCESSFULLY PROVIDED TO EVERYONE INVOLVED IN THE FOOD AND BEVERAGE OPERATION.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

! New Order: 2-200 Employee Health2-201.11B *Priority Level: Priority 1 CFP#: 3*

MN Rule 4626.0040B The person in charge shall notify the regulatory authority of a food employee known to be infected with norovirus, hepatitis A virus, Salmonella spp., Shigella spp., Shiga toxin-producing Escherichia coli, or other enteric bacterial, viral, or parasitic pathogens.

COMMENT: PERSON IN CHARGE (PIC) UNAWARE OF NOTIFICATION REQUIREMENTS. NOTIFICATION REQUIREMENTS REVIEWED WITH PIC, AS WERE THE "BIG 5" COMMON CONTAGIOUS FOODBORNE ILLNESS PATHOGENS IN MINNESOTA. THE REQUIREMENT FOR FOOD SERVICE WORKERS TO REPORT THEIR SYMPTOMS OF FOODBORNE ILLNESS TO THE PIC WAS ALSO DISCUSSED.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: UNPASTEURIZED SHELL EGGS ABOVE RTE ITEMS IN REFRIGERATOR WITHOUT SUFFICIENT SEPARATION TO PREVENT POSSIBLE CONTAMINATION. OPERATOR INSTRUCTED TO MOVE UNDER RTE FOODS AND/OR STORE IN A CONTAINER WITH FEATURES THAT COULD PREVENT CROSS CONTAMINATION, SUCH AS A 6" DEEP CLEAR POLYCARBONATE FOOD PAN OR SIMILAR TYPE OF HOLDING VESSEL CAPABLE OF HOUSING FLATS OF EGGS.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

! New Order: 3-500B Microbial Control: hot and cold holding3-501.16A2 *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: 9/13/23-6/24/25: TCS FOODS IN REFRIGERATOR TEMP ABUSED. DISCARDED BY OPERATOR. REFRIGERATOR ADJUSTED FROM 3 TO 4 WITH 7 BEING THE COLDEST SETTING. OPERATOR INSTRUCTED TO ADJUST AS NEEDED TO MEET SAFE HOLDING TEMPERATURES AND VERIFY SAFE TEMPS BEFORE PLACING MORE TCS FOODS INTO REFRIGERATOR.

Comply By: 9/13/2023 Originally Issued On: 6/24/2025

New Order: 3-500C Microbial Control: date marking3-501.17B *Priority Level: Priority 2 CFP#: 23*

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date. COMMENT: NO DATE MARK ON OPENED BAG OF SHREDDED CHEESE. OPERATOR INSTRUCTED TO DATE MARK REQUIRED ITEMS, DISCARD AFTER 7-DAY USE WINDOW, AND TO NOT EXCEED THE MANUFACTURER'S SELL BY DATE.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

New Order: 4-100 Equipment Construction Materials4-101.17 *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0490* Discontinue using wood and wood wicker as a food contact surface.

COMMENT: WOOD DRYING RACK. OPERATOR INSTRUCTED TO REMOVE.

*Comply By: 6/24/2025 Originally Issued On: 6/24/2025***New Order: 4-200 Equipment Design and Construction**4-204.112A *Priority Level: Priority 3 CFP#: 36**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.

COMMENT: INTERNAL THERMOMETERS PRESENT IN COOLER BUT NONE WORKING. OPERATOR INSTRUCTED TO ENSURE A TEMP MEASURING DEVICE IS LOCATED IN THE WARMEST PART OF THE REFRIGERATOR TO VERIFY SAFE HOLDING TEMPS. INDEPENDENT INTERNAL THERMOMETER PROVIDED TO OPERATOR FOLLOWING THE INSPECTION.

*Comply By: 6/24/2025 Originally Issued On: 6/24/2025***New Order: 4-300 Equipment Numbers and Capacities**4-302.13B *Priority Level: Priority 2 CFP#: 48**MN Rule 4626.0710B* Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: NO THERMAL STICKERS OR MIN/MAX THERMOMETER TO VERIFY SANITIZING DISHWASHER'S MAX TEMP. OPERATOR INSTRUCTED TO OBTAIN MEANS TO PERIODICALLY VERIFY DISHWASHER IS REACHING MANUFACTURER'S PURPORTED SANITIZING TEMP: SAMSUNG DW80M2020US - 156 °F (69 °C) IN ACCORDANCE WITH NSF/ANSI STANDARD 184. SINGLE THERMAL STICKER PROVIDED TO OPERATOR WITH INSTRUCTIONS ON TESTING.

*Comply By: 6/24/2025 Originally Issued On: 6/24/2025***! New Order: 4-500 Equipment Maintenance and Operation**4-501.114A *Priority Level: Priority 1 CFP#: 16**MN Rule 4626.0805A* Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

COMMENT: ESTABLISHMENT USING MULTI-PURPOSE DISINFECTANT WITHOUT EPA REG. NO. ON COUNTERS AND OTHER FOOD CONTACT SURFACES. OPERATOR INSTRUCTED TO DISCONTINUE USING ON FOOD CONTACT SURFACES. OPERATOR SUBSEQUENTLY PRODUCED WIPES INTENDED FOR FOOD CONTACT SURFACES WITH EPA REG. NO. 9896-2. OPERATOR INSTRUCTED TO ONLY USE CHEMICALS INTENDED FOR FOOD CONTACT SURFACES ON FOOD CONTACT SURFACES.

*Comply By: 6/24/2025 Originally Issued On: 6/24/2025***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: AREAS OF KITCHEN WORN, WITH SLIGHT GAPS, AND/OR NOT UP TO FINISH MATERIAL STANDARDS. MAINTAIN SANITARY AND PEST FREE. FINISHES AND JUNCTURES MUST BE BROUGHT INTO ACCEPTABLE STANDARDS IF A REMODEL OCCURS OR IF SANITARY PEST FREE CONDITIONS CANNOT BE MAINTAINED.

*Comply By: 6/24/2025 Originally Issued On: 6/24/2025***New Order: 6-300 Physical Facility Numbers and Capacities**6-301.12 *Priority Level: Priority 2 CFP#: 10**MN Rule 4626.1445* Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

COMMENT: NO PAPER TOWELS AT HANDWASHING SINK. CORRECTED DURING INSPECTION. OPERATOR INSTRUCTED TO ALWAYS MAINTAIN SUPPLY OF PAPER TOWELS AT HANDWASHING SINK.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control6-501.19 *Priority Level: Priority 3 CFP#: 53**MN Rule 4626.1555* Keep the toilet room doors closed except during cleaning and maintenance operations.

COMMENT: BATHROOM DOORS OPEN. COS. OPERATOR INSTRUCTED TO KEEP CLOSED WHEN NOT MAINTAINING OR CLEANING.

*Comply By: 6/24/2025 Originally Issued On: 6/24/2025***! New Order: 7-200 Toxic Supplies and Applications**7-207.11B *Priority Level: Priority 1 CFP#: 28**MN Rule 4626.1660B* Label and locate personal medications in areas that do not contaminate food, equipment, linens, and single-service and single-use articles.

COMMENT: INSULIN IN REFRIGERATOR WITH FOODS AND BEVERAGES. OPERATOR INSTRUCTED TO NOT STORE MEDICATIONS IN FOOD AND BEVERAGE COOLERS OR ANY OTHER AREA THAT MAY CONTAMINATE ITEMS IN THE FOOD AND BEVERAGE OPERATION. NURSE EVALUATOR NOTIFIED THAT INSULIN HAD BEEN STORED IN FOOD AND BEVERAGE COOLER AND MAY HAVE ENTERED AN UNSAFE HOLDING TEMPERATURE (> 46°F) GIVEN THE IDENTIFIED TEMP ABUSED FOODS.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

Food & Beverage General Comment

Inspection conducted with Said Ali, PIC LALD, and the establishment's house manager. All identified issues reviewed during and after the inspection. Employee illness logging, exclusion, and notification requirements reviewed, in addition to hygiene and handwashing, temperature control, date marking, sanitizing, requirements for serving a highly susceptible population, protection from contamination, and other foodborne illness risk factors.

Kitchen and equipment are residential, and food is prepared for same day service.

Cat present in house but cat's food and water dishes outside of kitchen area. Operator instructed to ensure cat does not interact with the food and beverage service. Cat not observed near kitchen during inspection.

Insulin observed in refrigerator and the possibility of temperature abuse was communicated.

"..Insulin from various manufacturers is often made available to patients in an emergency and may be different from a patient's usual insulin. After a disaster, patients in the affected area may not have access to refrigeration. According to the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36°F to 46°F. Unopened and stored in this manner, these products maintain potency until the expiration date on the package.

Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days and continue to work. However, an insulin product that has been altered for the purpose of dilution or by removal from the manufacturer's original vial should be discarded within two weeks..."

- <https://www.fda.gov/drugs/emergency-preparedness-drugs/information-regarding-insulin-storage-and-switching-between-products-emergency>

Establishment serves 3 clients that are all part of a highly susceptible population.

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 Metro District Office inspection report number F1029251045 from 6/24/2025

Trevor McCliment

SAID ALI
LALD

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
Butterfly Assisted Living LLC	Report Number: F1029251045
Coon Rapids	Inspection Type: Full
County/Group: Anoka County	Date: 6/24/2025
	Time: 2:30:41 PM

New Record: Product/Item/Unit: MILK; Temperature Process: COLD HOLDING

Location: COOLER CAVITY at 46 Degrees F.

Comment:

Violation Issued?: Yes

New Record: Product/Item/Unit: MILK; Temperature Process: COLD HOLDING

Location: COOLER CAVITY at 47 Degrees F.

Comment:

Violation Issued?: Yes

New Record: Product/Item/Unit: SHREDDED CHEESE; Temperature Process: COLD HOLDING

Location: COOLER DOOR at 46 Degrees F.

Comment:

Violation Issued?: Yes

New Record: Product/Item/Unit: JELLO PARFAIT; Temperature Process: COLD HOLDING

Location: COOLER CAVITY at 46 Degrees F.

Comment:

Violation Issued?: Yes

New Record: Product/Item/Unit: QUESO; Temperature Process: COLD HOLDING

Location: COOLER DOOR at 50 Degrees F.

Comment:

Violation Issued?: Yes

New Record: Product/Item/Unit: GRATED PARMESAN; Temperature Process: COLD HOLDING

Location: COOLER DOOR at 52 Degrees F.

Comment:

Violation Issued?: Yes

New Record: Product/Item/Unit: SHELL EGG; Temperature Process: COLD HOLDING

Location: COOLER CAVITY at 45 Degrees F.

Comment:

Violation Issued?: No



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Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
Butterfly Assisted Living LLC	Report Number: F1029251045
Coon Rapids	Inspection Type: Full
County/Group: Anoka County	Date: 6/24/2025
	Time: 2:30:41 PM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Food Establishment Inspection Report

 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164	No. of Risk Factor/Intervention/Violations		8	Date: 6/24/2025
	No. of Repeat Risk Factor/Intervention/Violations			Time: 2:30:41 PM
	Score (optional)			Dur: min
Establishment: Butterfly Assisted Living LLC	Address: 12 98th Lane NW	City/State: Coon Rapids, MN	Zip: 55448	Phone: 763-264-6067
License/Permit #: 0039271 29188	Permit Holder: SAID ALI	Purpose of Inspection: Full	Est. Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation				
Compliance Status			COS	R	Compliance Status			COS	R
Supervision					Time/Temperature Control for Safety				
1	OUT	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	OUT	Certified Food Protection Manager			19	N/O	Proper reheating procedures for hot holding		
Employee Health					20	N/O	Proper cooling time and temperature		
3	OUT	knowledge, responsibilities, and reporting			21	N/O	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	OUT	Proper cold holding temperatures		
5	IN	Response to vomiting, diarrheal events			23	OUT	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	N/O	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	N/O	Hands clean and properly washed			26	IN	Pasteurized foods used; prohibited foods not offered		
9	N/O	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	OUT	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	OUT	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	OUT	Food separated and protected							
16	OUT	Food-contact surfaces; cleaned & sanitized							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" or OUT 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				COS	R
Safe Food and Water					Proper Use of Utensils				
30	N/A	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/O	Plant food properly cooked for hot holding			47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48	X	Warewashing facilities: installed, maintained, used; test strips		
36	X	Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53	X	Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55	X	Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)					57		Compliance with MCIAA		
					58		Compliance with licensing and plan review		

Inspector (signature)	<i>Trevor McClime</i>	Follow-up:	Follow-up Date:
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