DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 18, 2023

Licensee
Butterfly Assisted Living LLC
12 98th Lane Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL39271015

Dear Licensee:

On December 5, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 13, 2023, survey were corrected. 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,

Carrie Euerle, Supervisor
State Evaluation Team
Email: carrie.euerle@state.mn.us
Telephone: 651-242-8846 Fax: 1-866-890-9290

HHH

Electronically Delivered
October 20, 2023

Licensee
Butterfly Assisted Living LLC
12 98th Lane Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL39271015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 13, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

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
Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

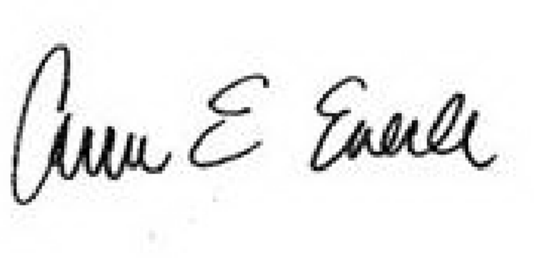
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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

If you have any questions, please contact me.

Sincerely,



Carrie Euerle, Supervisor
State Rapid Response Team
Email: Carrie Euerle
Telephone: 651-242-8846 Fax: 1-800-337-9238

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39271	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY ASSISTED LIVING LLC	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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39271015 On September 12, 2023, the Minnesota Department of Health conducted a provisional survey at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there was 1 resident receiving services under the provider's Provisional Assisted Living license. The following immediate correction order was issued on September 12, 2023, for SL39271015 , tag identification_ 2310. Correction orders with a period to correct that are not immediate may be issued at a later date during the survey. On September 13, 2023, at 10:00 a.m., the immediacy of correction order 2310 has been removed, however non compliance remained at a scope and level of G.	0 000		

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect one resident residing at 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated September 13, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480	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 License Providers. 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 surveyors' 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.	

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0 480	Continued From page 2	0 480	The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 630 SS=F	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 upon admission and included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	0 630		

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0 630	Continued From page 3 The findings include: R1's facesheet indicated R1 was admitted on August 1, 2023, with diagnoses including type 2 diabetes, history of a stroke, and high blood pressure. R1's service plan dated August 14, 2023, indicated R1 received assistance with dressing, grooming, medications administration, behavior management and blood glucose checks. R1's Individual Abuse Prevention Plan (IAPP) dated August 31, 2023, did not include abuse prevention regarding self abuse and failed to include the required content of: -the person's risk of abusing other vulnerable adults; -and statement of the specific measure to be taken to minimize the risk of abuse to that person and other vulnerable adults. On September 13, 2023, at 10:50 a.m., registered nurse (RN)-B stated the IAPP needed to be completed within 14 days and was not aware of the content required. The licensee's Vulnerable Adult Policy dated July 20, 2022, indicated all residents will be assessed to determine vulnerability to abuse or neglect and develop a specific plan to minimize the risk of abuse. The policy also indicated the assessment of vulnerability status of each resident upon admission and susceptibility of abuse including self abuse, neglect and risk of abuse by other individuals, including other vulnerable adults in the following areas: 1) Physical; 2) Verbal; 3) Sexual; 4) Financial Exploitation; and 5) Self abuse.	0 630		

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0 630	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed TB Facility Risk Assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 5 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to complete a TB risk assessment, including designating and documenting a qualified person or team with primary responsibility for the TB infection control program. On September 12, 2023, at 2:26 p.m., the licensed assisted living director (LALD)-A confirmed the facility had not completed a TB risk assessment, and all the requirements within the risk assessment. The licensee's Tuberculosis Screening/Prevention policy, dated July 20, 2022, indicated the Director is responsible for conducting the formal TB risk assessment and updating it annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 6 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on September 13, 2023, at approximately 3:00 p.m. with unlicensed personnel (ULP)-C it was observed that the fire extinguisher installed was not maintained annually by certified personnel as required by MN Statute 144G.45. Fire extinguishers are required to be maintained annually by certified personnel in accordance with MN Statute 144G.45. ULP-C visually verified this deficient finding at the	0 790		

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0 790	Continued From page 7 time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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). Findings include: On a facility tour on September 13, 2023, at approximately 3:00 p.m. with unlicensed	0 800		

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0 800	Continued From page 8 personnel (ULP)-C it was observed that an exit sign was posted on the door leading from the house to the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. The main front entrance door is required to be maintained as the required exit from the facility. This deficient condition was visually verified by ULP-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 9 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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). Findings include: A record review of available documentation and interview were conducted on September 13, 2023, at approximately 2:30 p.m. of documents provided by unlicensed personnel (ULP)-C on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 10 Record review of the available documentation indicated that the licensee did not provide number and location of resident rooms on the fire safety and evacuation floor plan. Resident room numbers are required to be included on the fire safety and evacuation floor plan for more accurate reference and communication of direction for evacuation. Record review of the available documentation indicated that the licensee included employee actions related to fire safety and evacuation but did not have specific employee actions for this specific facility and building located within the plan. Specific employee actions required for this specific facility are required to be included in the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Facility fire safety and evacuation plan employee training is required to be completed and documented separately from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Resident training on the fire safety and evacuation plan for	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY ASSISTED LIVING LLC	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
0 810	Continued From page 11 the facility is required to be offered to the residents once annually. All deficiencies were verified by ULP-C during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one residents (R1) with records reviewed. 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	0 910		

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0 910	Continued From page 12 the residents). The findings include: The licensee lacked a written contract with the following required content: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility R1's Resident Contract for Assisted Living dated, August 1, 2023, indicated the licensee held an Assisted Living license, however the contract lacked requirements noted above. On September 12, 2023, at 3:00 p.m. licensed assisted living director (LALD)-A confirmed the contract lacked the requirements noted above and stated he thought he had updated that. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability	01440		

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01440	Continued From page 13 to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of supervision of staff performing delegated nursing tasks was completed for one of one unlicensed personnel (ULP)-C. This had the potential to affect one resident. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: ULP-C's record was reviewed on September 12, 2023. ULP-C was hired on July 1, 2023.	01440		

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01440	Continued From page 14 ULP-C's employee record lacked evidence that direct supervision was performed by a registered nurse (RN) within 30 days after orientation and competency training to verify competency in performing the task and to identify problems and solutions to address issues relating to the ULP's ability to provide the services. During an interview on September 12, 2023, at 3:16 p.m. licensed assisted living director (LALD)-A confirmed the only form he had related to documentation of staff supervision was the Individualized Treatment and Therapy Plan which did not identify ULP-C as the employee being supervised. The licensee's Supervision: Unlicensed Staff policy, dated July 20, 2022, indicated the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs delegated tasks for residents, and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	01440		
01610 SS=D	144G.70 Subd. 2 (a-b) 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	01610		

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01610	Continued From page 15 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a nursing assessment of the resident on or before move-in for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's contract was dated and signed on August 1, 2023. R1 was admitted on August 1, 2023, with diagnoses including type 2 diabetes, high blood pressure and history of a stroke. R1's service plan dated August 14, 2023,	01610		

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01610	Continued From page 16 indicated R1 received assistance with dressing, grooming, medications administration, behavior management and blood glucose checks. R2's initial nursing assessment was dated August 2, 2023. R2's next nursing assessment was dated August 31, 2023. On September 13, 2023, registered nurse (RN)-B stated the initial assessment was completed one day after R1 was admitted. RN-B stated she was not aware of the timeline requirements for assessments until recently. The licensee's Comprehensive Nursing Assessment policy dated July 20, 2022, indicated the RN will conduct a comprehensive assessment for all resident and shall be completed prior to the date on which the prospective resident executes a contract or on the date on of admission, whichever is earlier. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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01620	Continued From page 17 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a 14-day reassessment 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 on August 1, 2023, with diagnoses including type 2 diabetes, high blood pressure and history of a stroke. R1's service plan dated August 14, 2023,	01620		

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01620	Continued From page 18 indicated R1 received assistance with dressing, grooming, medications administration, behavior management and blood glucose checks. R1's initial Nursing Assessment was dated August 2, 2023. R1's next nursing assessment was dated August 31, 2023. R1's record did not include a 14 day assessment. On September 13, 2023, registered nurse (RN)-B stated a 14 day assessment was not completed and was not aware of the timeline requirements for assessments until recently. The licensee's Assessment and Reassessment policy dated July 20, 2022, indicated the RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01630 SS=D	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to initiate a temporary service plan for one of one resident (R1) with records reviewed.	01630		

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01630	Continued From page 19 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's contract was dated and signed on August 1, 2023. R1 was admitted on August 1, 2023, with diagnoses including type 2 diabetes, high blood pressure and history of a stroke. R1's service plan dated August 14, 2023, indicated R1 received assistance with dressing, grooming, medication administration, behavior management and blood glucose checks. R1's record did not include a temporary service plan dated prior to August 14, 2023. R1's Schedule of Care document indicated R1 received services including medication management services, and blood glucose monitoring beginning August 1, 2023. On September 13, 2023, at 11:00 a.m., registered nurse (RN)-B stated R1 admitted to the facility on August 1, 2023, and R1's service plan was completed on August 14, 2023. RN-B stated they asked R1 what services were needed prior to completion of the service plan.	01630		

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01630	Continued From page 20 The licensee's Service Plan policy dated July 20, 2022, indicated a temporary service plan and agreement with the resident will be developed if services are initiated and the individualized assessment has not been completed. The temporary service plan shall not be effective for more than 72 hours. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01630		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 21 (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 record review and interview, the licensee failed to ensure an individualized medication management plan was completed to include all required contents for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a residents 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 on August 1, 2023, with diagnoses including type 2 diabetes, high blood	01730		

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01730	Continued From page 22 pressure and history of a stroke. R1's service plan dated August 14, 2023, indicated R1 received assistance with dressing, grooming, medication administration, behavior management and blood glucose checks. R1's admission assessment dated August 2, 2023, indicated the resident required reminders for taking prescribed medications and staff would assist R1 with setting up the medication and administering. The assessment indicated R1 received the following medications: Amlodipine (high blood pressure) daily, aspirin daily, atorvastatin (treats high cholesterol) daily, chlorthalidone (high blood pressure) daily, empagliflozin (antidiabetic) daily, lisinopril (high blood pressure) daily, metformin (antidiabetic) daily and nicotine gum. R1's individualized Medication Management Plan dated September 12, 2023, indicated R1 required full medication management and set up. The following content was not included in R1's plan: -description of storage of medications based on the resident's needs and preferences; -risk of diversion and per manufacturer's directions; -documentation of specific resident instructions relating to the administrations of medications; -identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services. On September 13, 2023, at 11:00 a.m., registered nurse (RN)-B stated R1's assessment should have been completed upon admisson but was not	01730		

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01730	Continued From page 23 aware of the required content of the medication management plan. The licensee's Assessment of Medications policy dated July 20, 2022, indicated the RN will complete an assessment to determine what medication management services will be provided and how they will be implemented according to Minnesota Rules 4659.0150. No further information was provided. TIME PERIOD FOR CORRECTION: 7-days	01730		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed 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 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).	01770		

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01770	Continued From page 24 The findings include: R1's contract was dated and signed on August 1, 2023. R1 was admitted on August 1, 2023, with diagnoses including type 2 diabetes, high blood pressure and history of a stroke. R1's admission assessment dated August 2, 2023, indicated the resident required reminders for taking prescribed medications and staff would assist R1 with setting up the medication and administering. The assessment indicated R1 received the following medications: Amlodipine (high blood pressure) daily, aspirin daily, atorvastatin (treats high cholesterol) daily, chlorthalidone (high blood pressure) daily, empagliflozin (antidiabetic) daily, lisinopril (high blood pressure) daily, metformin (antidiabetic) daily and nicotine gum. R1's service plan dated August 14, 2023, indicated R1 received assistance with dressing, grooming, medication administration with set up by the registered nurse (RN), behavior management and blood glucose checks. R1's individualized Medication Management Plan dated September 12, 2023, indicated R1 required full medication management and set up. During an observation, on September 13, 2023, at 8:30 a.m., unlicensed personnel (ULP)-E unlocked the medication cabinet and took out R1's medication planner. ULP-E stated she knew what medications were in the planner since the bottles of medication were in the cabinet also. The medications planner did not include identification of what medications were set up.	01770		

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01770	Continued From page 25 ULP-E stated the RN set up the medications weekly. ULP-E then administered 6 pills to R1. On September 13, 2023, at 11:00 a.m., RN-B stated she set up R1's medications but verified there was no documentation of what medications were set up in R1's medication planner. The licensee's Medication Management Documentation policy dated July 20, 2022, indicated documentation of medication administration and medications set up will be completed promptly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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	39271	A. BUILDING: _____ B. WING _____	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY ASSISTED LIVING LLC	12 98TH LANE NORTHWEST COON RAPIDS, MN 55448

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01940	Continued From page 26 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on September 12, 2023, at 11:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment management services to their	01940		

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01940	Continued From page 27 residents. R1 was admitted on August 1, 2023, with diagnoses including type 2 diabetes, high blood pressure and history of a stroke. R1's service plan dated August 14, 2023, indicated R1 received assistance with dressing, grooming, medications administration, behavior management, blood glucose checks twice daily and oxygen saturation three times daily. R1's admission assessment dated August 2, 2023, indicated the resident required reminders for taking prescribed medications and staff would assist R1 with setting up the medication and administering. R1's Individualized Treatment and Therapy Plan dated September 13, 2023, was completed by licensed assisted living director (LALD)-A. There were no other treatment or therapy assessments prior to this assessment. R1's record indicated R1 required blood glucose checks since admission on August 1, 2023. During an observation, on September 13, 2023, unlicensed personnel (ULP)-E completed R1's blood glucose check. The licensee's Treatment and Therapy Management policy dated July 20, 2022, indicated a RN or other licensed professional will complete an assessment of all residents receiving treatment or therapy services prior to the initiation of those services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940		

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01940	Continued From page 28 days	01940		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care, medical, or nursing standards for one of one residents (R1) who utilized side rails (bed rails). This resulted in an immediate correction order on September 12, 2023, at 2:45 p.m. 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 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's diagnoses included type two diabetes and history of stroke. R1's service plan dated August 14, 2023, indicated R1 required assistance with dressing, grooming, medication administration, transferring	02310		

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02310	Continued From page 29 assistance, and blood glucose monitoring. R1's assessment dated August 31, 2023, indicated the licensee provided a bed rail to help R1 sit up. The assessment indicated R1 required intermittent assistance with transfers due to unsteadiness. The assessment also indicated R1's orientation varied by the time of day and had minor forgetfulness. The assessment identified the bed safety zone assessment was not completed because R1 had portable bed rails installed on a consumer bed or the resident has no bed rails. The assessment indicated R1 had a brand new side rail but no other information was documented. On September 12, 2023, at 11:55 a.m. the surveyor observed R1 had a side rail attached to the bed. Zone 3 (area between the mattress and siderail) appeared to be larger than the recommended width to prevent entrapment. R1 stated he used the side rail sometimes to get out of bed. On September 12, 2023, at 1:15 p.m., licensed assisted living director (LALD)-A stated he did not have anything to measure the safety zones and would have to go and get a tape measure. On September 12, 2023, at 2:00 p.m., LALD-A measured zone 3 for R1's side rail and it measured 8.5 inches from the side rail to the mattress. LALD-A was not aware of the zone requirements. At 2:38 p.m., LALD-A measured zone 1 at 15.25 inches, zone 4 and 5 were not applicable, and zone 6 measured 19 inches. LALD-A again stated he was not aware of the zone requirements. On September 12, 2023, at 2:10 p.m., registered	02310		

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02310	Continued From page 30 nurse (RN)-B stated she was not aware of the zone requirements for side rails but stated she made sure R1 was safe to use the side rail. When RN-B was informed of zone 3 requirements and was told the measurements were 8.5 inches. RN-B stated, "Oh, that's too far, that is something we can work on." The RN stated the Side Rail Use policy should be followed. RN-B stated the side rail should be snug to the mattress. The Smart-Rail manufacturer information was located in a plastic bag attached to the side rail. The information included a section titled "Warning- Patient Entrapment" and indicated the potential for entrapment between the rail and the bed can be reduced or avoided by considering situations that could change with time or usage such as mattress compression or patient movement and realizing the side rail is not a physical constraint or barrier. The information also included directions for installation and pictured the side rail snug to the mattress. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Food and Drug Administration (FDA),	02310		

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02310	Continued From page 31 "Recommendations for Health Care Providers about Bed Rails," dated July 9, 2018, included the following information: -Follow the health care facility's procedures and/or manufacturer's recommendations/specifications for installing and maintaining bed rails for the particular bed frame and bedside rails used. -Inspect and regularly check the mattress and bedrail's to make sure they are still installed correctly and for areas of possible entrapment and falls. Regardless of mattress width, length, and/or depth, the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. -Regularly assess that bed rails remain appropriately matched to the equipment and to the patient's needs, considering all relevant risk factors. -Inspect, evaluate, maintain, and upgrade equipment (beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards. -Re-assess the person's needs and re-evaluate the equipment if an episode of entrapment or near-entrapment occurs, with or without serious injury. This should be done immediately because fatal "repeat" events can occur within minutes of the first episode. -Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or water bed. -When in doubt, call the manufacturer of the rails for assistance. The licensee's Side Rail Use policy, dated July 20, 2022, indicated before implementing side rails	02310		

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02310	Continued From page 32 for a resident, the RN will conduct a side rail assessment. Potential risks of side rails include: Injuries form falls if the resident attempts to climb over the rails; strangling, suffocating, bodily injury or death when residents or part of their body are caught between rails or between the side rails of the mattress; feeling of isolation or restriction of movement. TIME PERIOD FOR CORRECTION: Immediate The immediacy was removed as confirmed by surveyor's on-site observation on September 13, 2023, and reviewed by evaluation supervisor on September 13, 2023, however noncompliance remains at a scope and severity of G. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *09/13/23*
Time: 10:00:00
Report: 1005231209

Food and Beverage Establishment Inspection Report

Location:
Butterfly Assisted Living LLC
12 98th Lane NW
Coon Rapids, MN55448
Anoka County, 02

Establishment Info:
ID #: 0042029
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS FOOD IN THE KITCHEN REFRIGERATOR WAS ABOVE 41 DEGREES F. REFRIGERATOR WAS TURNED TO A COLDER SETTING.

Comply By: 09/13/23

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 43 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: Cold Hold/OJ
Temperature: 44 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH PERSON IN CHARGE AND REVIEWED WITH HRD NURSE EVALUATOR, ERIN JOHNSON-CROSBY.

DISCUSSED ORDER ON REPORT AS WELL AS COOKING TEMPERATURES, DATE MARKING, AND SANITIZATION. FACILITY HAS TEMPERATURE SENSITIVE STRIPS FOR THE DISHWASHER AND PERSON IN CHARGE SAID THEY TURN BLACK (REACH AT LEAST 160 DEGREES F) WHEN RUN THROUGH THE DISHWASHER.

THERE IS A CAT THAT LIVES IN THE HOME AS WELL. DISCUSSED MOVING CAT'S FOOD AND WATER DISHES OUT OF THE KITCHEN AND TRYING TO KEEP IT OUT OF THE KITCHEN AS MUCH AS POSSIBLE, ESPECIALLY DURING FOOD PREPARATION.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS LAMINATE, CABINETS ARE WOOD WITH HOLLOW BASE, COUNTERS ARE LAMINATE, AND THE CEILING IS TEXTURED. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1005231209 of 09/13/23.

Certified Food Protection Manager: HASSAN A ALI

Certification Number: FM113663 Expires: 09/08/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
SAID ALI

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us