Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 29, 2024

Licensee
Butterfly Bound Care
6207 Chowen Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL32914015

Dear Licensee:

On January 23, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 1, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 1, 2023 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 1, 2023, found not corrected at the time of the January 23, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b)-(f) - $500.00

The details of the violations noted at the time of this follow-up survey completed on January 23, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

IMPOSITION OF FINES:

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.

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.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Bob Dehler at 651-201-3710.

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.

Sincerely,



Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32914	A. BUILDING: _____ B. WING _____	R 01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	6207 CHOWEN AVENUE NORTH BROOKLYN CENTER, MN 55429

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{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL32914015-1 On January 23, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 01, 2023. At the time of the survey, there were 04 residents; 04 receiving services services license. As a result of the revisit, the following orders were reissued.	{0 000}		
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services;	{0 250}		

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{0 250}	Continued From page 1 (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the	{0 250}		

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{0 250}	Continued From page 2 assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action required.	{0 250}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced	{0 470}		

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{0 470}	Continued From page 3 by: No further action required.	{0 470}		
{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: No further action required.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 510}		
{0 650} SS=F	144G.42 Subd. 8 Employee records	{0 650}		

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{0 650}	Continued From page 4 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{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	{0 660}		

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{0 660}	Continued From page 5 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: No further action required.	{0 660}		
{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; 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	{0 680}		

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{0 680}	Continued From page 6 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	{0 810}		

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{0 810}	Continued From page 7 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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 observation on January 23, 2024, at 10:30 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff accessibility. On January 25, 2024, licensed assisted living director/licensed practical nurse (LALD/LPN)-D emailed documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility to survey staff. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Policy", dated 8/01/2021, failed to include the following:	{0 810}		

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{0 810}	Continued From page 8 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. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on January 29, 2024, at 1:00 p.m., LALD/LPN-D stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance. No further information was provided.	{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	{01060}		

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{01060}	Continued From page 9 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 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: No further action required.	{01060}		
{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	{01500}		

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{01500}	Continued From page 10 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), 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	{01500}		

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{01500}	Continued From page 11 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: No further action required.	{01500}		
{01620} SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.	{01620}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01620}	Continued From page 12 (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: No further action required.	{01620}		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	{01640}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32914	A. BUILDING: _____ B. WING _____	R 01/23/2024

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{01640}	Continued From page 13 by: No further action required.	{01640}		
{01730} SS=F	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; (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.	{01730}		

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{01730}	Continued From page 14 (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: No further action required.	{01730}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{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	{01880}		

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{01880}	Continued From page 15 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01890} SS=F	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: No further action required.	{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 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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{01940}	Continued From page 16 (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: No further action required.	{01940}		

Electronically Delivered

November 28, 2023

Licensee
Butterfly Bound Care
6207 Chowen Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL32914015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (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 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $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 the MDH 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.

To submit a reconsideration request, please visit:

https://www.web.health.state.mn.us/form/HRD-Appeals-Form

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 MDH 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://www.web.health.state.mn.us/form/HRD-Appeals-Form**.

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.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32914	A. BUILDING: _____ B. WING _____	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	6207 CHOWEN AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32914015-0 On October 30, 2023, through November 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents all of whom received services under the Assisted Living license. An immediate correction order was identified on October 30, 2023, issued for SL32914015-0, tag identification 0820. On October 31, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	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 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. 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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: During the entrance conference on October 30,	0 250		

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0 250	Continued From page 3 2023, at 9:52 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250		

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by LALD/LPN-D on December 3, 2022. The licensee had an assisted living license issued on January 1, 2023, with an expiration date of December 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - competency evaluations of staff, - conducting ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;	0 250		

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0 250	Continued From page 6 - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; On November 1, 2023, at 10:30 a.m., LALD/LPN-D and clinical nurse supervisor (CNS)-C confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0470, 0480, 0510, 0650, 0660, 0680, 0790, 0800, 0810, 0820, 1060, 1500, 1620, 1640, 1730, 1760, 1880, 1890, and 1940 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies	0 470		

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	32914	A. BUILDING: _____ B. WING _____	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	6207 CHOWEN AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 470	Continued From page 7 and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: The licensee held an assisted living license. The	0 470		

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0 470	Continued From page 8 facility was licensed for a bed capacity of four residents and had a current census of four residents. On October 31, 2023, at 5:57 p.m., via email correspondence, the surveyor received an undated staffing plan from business office manager/housing manager (BOC/HM)-B titled Staffing Plan for Chowen House. The staffing plan lacked an evaluation conducted by the CNS, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. On November 31, 2023, at 10:31 a.m., the surveyor inquired who created and reviewed the licensee's staffing plan. Clinical nurse supervisor (CNS)-C stated the licensee's staffing plan was created by licensed assisted living director/licensed practical nurse (LALD/LPN)-D and was updated and reviewed frequently by LALD/LPN-D and BOC/HM-B. In addition, CNS-C stated they were unfamiliar with the requirement. The licensee's Staffing Plan policy dated August 1, 2021, indicated the staffing plan was based on an evaluation of the appropriateness of the staffing levels in the facility and was reviewed twice per year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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:	0 480		

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0 480	Continued From page 9 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 30, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 10 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control related to pest control, dropped medication, and hand hygiene for three of four employees (unlicensed personnel (ULP)-A, licensed assisted living director/licensed practical nurse (LALD/LPN)-D, 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 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: COCKROACHES From October 30, 2023, through November 1, 2023, the surveyor observed multiple live cockroaches in the facility's kitchen, living room, and bathrooms. In addition, on October 23, 2023, the environmental health (EH) surveyor from the	0 510		

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0 510	Continued From page 11 Minnesota department of health (MDH) found multiple carcasses and live cockroaches in the facility's kitchen and food. On November 1, 2023, at 10:35 a.m., LALD/LPN-D stated "we have been battling they come and go." In addition, LALD/LPN-D stated they hired an exterminator who completed four treatment rounds however, it was unsuccessful, so the licensee continued to treat the cockroaches with a product they apply themselves which they found worked better than the exterminator. Clinical nurse supervisor (CNS)-C stated the licensee had an exterminator treat the facility and they came back. In addition, CNS-C stated they recently discussed the cockroach concern in a staff meeting. The University of Minnesota Extension document titled Cockroaches dated 2023, indicated cockroaches carry disease that can cause food poisoning or diarrhea and can irritate allergies and asthma in people. In addition, it was best to hire a pest management service to treat cockroaches. HAND HYGIENE/GLOVES ULP-A AND LALD/LPN-D On October 31, 2023, at 8:30 a.m., the surveyor observed ULP-A provide cares to R1. ULP-A applied gloves prior to the start of observation. ULP-A retrieved R1's clothes and removed one glove to fill a water basin with water in the shared bathroom down the hallway. Without performing hand hygiene, ULP-A applied a new glove to the one hand, elevated R1's bed, removed pillows, removed R1's gown, washed R1's face, neck, upper body, and abdomen, turned R1 to the side, washed R1's back, and removed gloves. Without performing hand hygiene, ULP-A applied a new	0 510		

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0 510	Continued From page 12 pair of gloves, applied Vaseline to R1's back, and removed gloves. Without performing hand hygiene, ULP-A applied a new pair of gloves, detached R1's incontinent product, preformed suprapubic catheter cares, and completed perineal care. Without glove removal or hand hygiene, ULP-A washed R1's bilateral front legs and feet, turned R1 to the side, removed the incontinent product and placed into the trash, washed R1's buttock and back of legs, and removed gloves. Without performing hand hygiene, ULP-A applied a new pair of gloves, applied Vaseline to R1's buttock and back of bilateral legs, applied a new incontinent brief to R1, and removed gloves. Without performing hand hygiene, ULP-A applied a new pair of gloves, applied Vaseline to R1's upper extremities, face, and front of legs and feet, applied deodorant to R1, dressed R1's upper and lower body, and removed gloves. Without performing hand hygiene, ULP-A applied a new pair of gloves, lowered R1's bed and called for assistance. LALD/LPN-D entered R1's room and without performing hand hygiene, applied gloves. LALD/LPN-D and ULP-A transferred R1 to the wheelchair with use of a mechanical lift. ULP-A exited R1's room without removal of gloves emptied water basin, returned to R1's room, removed gloves, exited R1's room, and performed hand hygiene in the kitchen. LALD/LPN-D made R1's bed, placed a blanket on R1, exited room without glove removal, retrieved a garbage bag, returned to R1's room, removed garbage and placed it in the new garbage bag, exited R1's room, gathered other trash and placed other garbage bags into the garbage bag that was brought into R1's room, exited the facility out the back door with garbage bag, returned into the facility without garbage bag, removed gloves, and performed hand hygiene.	0 510		

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0 510	Continued From page 13 On October 31, 2023, at 10:33 a.m., ULP-A stated they were trained on infection control through EduCare (a training software program). In addition, ULP-A stated they were trained to perform hand hygiene when they entered the facility, and after completing a task. The surveyor inquired when hand hygiene should be performed when gloves were used. ULP-A stated they changed gloves frequently throughout cares due to touching dirty parts of the body and sanitizer should be used between the glove changes unless there was bowel movement, then handwashing would be required. ULP-E On October 2023, at 7:48 a.m. to 8:11 a.m., the surveyor observed ULP-E providing cares to R2. ULP-E washed their hands and applied gloves. ULP-E provided R2 with a towel to cover, undressed lower extremities, provided a walker to R2, cued R2 to stand, walked R2 to the shared bathroom in the hallway, removed towel, and sat R2 on the toilet. Without removing gloves, ULP-E exited the bathroom into the shared hallway, then removed gloves. Without performing hand hygiene, ULP-E retrieved an item from a bin in R2's room, applied a new pair of gloves in the hallway, entered the bathroom, filled up a water basin and exited bathroom. Without removing gloves, ULP-E exited bathroom into shared hallway, retrieved incontinent brief and clothing from R2's room, brought items into bathroom, exited bathroom to retrieve soap, entered bathroom, placed soap into water bin, provided R2 with a washcloth, and cued R2 to wash face. Without removing gloves, ULP-E exited the bathroom into shared hallway, retrieved Vaseline from R2's bedroom, entered the bathroom, assisted R2 with removal of shirt, assisted R2	0 510		

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0 510	Continued From page 14 with hygiene of the chest, arms, and back, then applied Vaseline to R2's chest and back, applied R2's shirt, stood R2, and provided perineal cares which included bowel incontinence. Without glove removal or performing hand hygiene, ULP-E applied Vaseline to R2's back, thighs, and groin, applied a new incontinent brief, and removed gloves. Without performing hand hygiene, ULP-E exited the bathroom to the shared hallway, retrieved R2's walker, assisted R2 to sit on the walker, applied pants, socks, and shoes to R2, stood R2, raised clothing on the lower extremities of R2, assisted with R2's mobility back to room, sat R2 on the wheelchair, exited R2's room, and performed hand hygiene in the kitchen sink. On October 31, 2023, at 9:01 a.m., ULP-E stated in orientation they were trained on infection control by a trainer and the nurse. The surveyor inquired when hand hygiene should be performed. ULP-E stated after performing care, after touching bodily fluids, and touching contaminated surfaces. The surveyor inquired when gloves should be changed. ULP-E stated with incontinent changes or after touching contaminated items. In addition, ULP-E stated hand hygiene should be performed after glove removal. On November 1, 2023, at 10:33 a.m., CNS-C stated ULP were trained on infection control through EduCare and received a competency related to hand hygiene by a nurse. In addition, ULP were to perform hand hygiene before and after cares, with medication administration, wound care, and after completing a dirty task. The surveyor inquired if ULP were trained to perform hand hygiene before and after glove removal. CNS-C stated they were trained to either wash their hands or apply sanitizer and if the ULP	0 510		

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0 510	Continued From page 15 completed a glove change they should use sanitizer between glove applications. On November 1, 2023, LALD/LPN-D stated CNS-C was responsible for the infection control program however, LALD/LPN-D and business office coordinator/housing manger (BOC/HM)-B assist in monitoring the program. The surveyor inquired how they monitor the infection control program. LALD/LPN-D stated at time of hire they train on handwashing, how to clean equipment, and what to do if someone is sick to prevent infection from spreading. The surveyor inquired if they completed infection control audits. LALD/LPN-D stated "no", however if they notice something is not being completed appropriately reeducation would be provided. The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.2 (§ a,b,c,d,e,f) reads: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b) before performing an aseptic task or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee would observe the recommended precautions for home	0 510		

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0 510	Continued From page 16 care [assisted living] as identified by the CDC. In addition, hands should be washed at the following times: - after changing beds; - before assisting with medications; - before and after treatments; - after all pet care; - after housekeeping; - after emptying bed pans; - after assisting the resident to the toilet; - after removing items off the floor; - before preparing food; - before feeding residents; - after using the bathroom; - after coughing or sneezing; - after smoking; and - after removing gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 17 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained competency evaluations for three of three employees (unlicensed personnel (ULP)-A, business officer manager/housing manager (BOC/HM)-B, 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: R1's unsigned service plan dated October 30, 2023, indicated R1 received assistance with a cough assist device. ULP-A ULP-A was hired on December 14, 2022, to provide direct services to the residents.	0 650		

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0 650	Continued From page 18 On October 31, 2023, at 8:30 a.m., the surveyor observed ULP-A provide catheter care, bathing, dressing, and transfer assistance to R1. In addition, the surveyor observed ULP-A use the cough assist machine on R1. ULP-A's employee record included a Skill Competency document signed on March 17, 2023, which included hearing aids, eyeglasses care, urinal assistance, perineal cares, toileting assistance, bathing, skin care, shaving, nail care, oral cares, communication, vital signs, and dressing. The document contained two boxes next to each procedure for the evaluator to indicate if the personnel passed or failed. All pass/fail boxes were left blank and failed to indicate if ULP-A was competent in the skills listed above. ULP-A's employee record lacked demonstration of the the following competencies: -safe transfer techniques and ambulation; - range of motion and positioning -reading and recording temperature, pulse, and respirations of the resident; -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -dressing and assisting with toileting; -catheter cares; -medication administration; -blood glucose; -cough assist therapy; and -mechanical lifts. On October 30, 2023, BOC/HM-B stated ULP-A skills competency document that was incomplete they were unsure why it lacked a pass or fail and the other above training they did not know what happened to the documentation. On October 31, 2023, at 1041 a.m., ULP-A stated they were trained, and received a competency	0 650		

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0 650	Continued From page 19 evaluation by a registered nurse (RN) for medication administration, blood glucose, cough assist therapy catheters, mechanical lift, mobility, positioning, vital signs, dressing, grooming, mechanical lifts, bathing, and oral care. ULP-A stated, "they watched me for a competency. Everything they showed me they had to watch me to see if I was able to do it or not." BOC/HM-B BOC/HM-B was hired on October 25, 2020, to provide direct services to the residents and assist in management of the licensee's employee records, and to provide oversite of the licensee's staff and residents. On November 1, 2023, at approximately 8:30 a.m., the surveyor observed BOC/HM-B prepare and serve breakfast for residents who resided in the facility. On November 1, 2023, at 10:03 a.m., BOC/HM-B stated they have provided cough assist therapy to R1. In addition, BOC/HM-B stated they were trained, and received a competency evaluation by a registered nurse on cough assist therapy. BOC/HM-B's employee record lacked a competency on cough assist therapy. ULP-E ULP-E was hired on June 17, 2020, to provide direct services to the residents. ULP-E on October 31, 2023, from 7:48 a.m. through 8:26 a.m., the surveyor observed ULP-E complete dressing, toileting, grooming, and medication administration on R2. On October 31, 2023, 9:01 a.m., ULP-E stated	0 650		

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	32914	A. BUILDING: _____ B. WING _____	11/01/2023

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0 650	Continued From page 20 they have provided cough assist therapy to R1. In addition, ULP-E stated they were trained, and received a competency evaluation by a RN on cough assist therapy. ULP-E employee record lacked a competency on cough assist therapy. On November 1, 2023, at 10:42 a.m., clinical nurse supervisor (CNS)-C stated all ULP were trained and received a competency evaluation for the cough assist therapy. The surveyor requested documentation for the three employees listed above. CNS-C stated, "I have watched each person on it to make sure they are competent to use it but do not have a formal document." In addition, CNS-C stated ULP-A's competencies may be misplaced at the office location. The licensee's Personnel Records policy dated August 1, 2021, indicated competency evaluations would be kept in the personnel record. In addition, each personnel record shall be maintained for at least three years after an employee ceases to be employed by licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 660		

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0 660	Continued From page 21 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include a current facility TB risk assessment. 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: The facility TB risk assessment form dated November 22, 2021, indicated the facility was at a low risk for TB transmission and the licensee would conduct or update TB risk assessment annually. The licensee lacked an updated TB risk assessment.	0 660		

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0 660	Continued From page 22 On November 1, 2023, 10:53 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated the TB risk assessment "was completed when the regulations changed". In addition, LALD/LPN-D stated they were unaware of the yearly requirement for the TB risk assessment. The Minnesota Department of Health (MDH) Facility Tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings Licensed by MDH, updated June 2023, and based on CDC guidelines, indicated facilities should perform a facility risk assessment on an annual basis. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, 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		
0 680 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	0 680		

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0 680	Continued From page 23 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain 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. 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: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - annual review;	0 680		

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0 680	Continued From page 24 - quarterly review of missing resident policy; - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans; - identify which staff would assume specific roles in another's absence through succession planning and delegation of authority that was updated with current employees; - arrangements with other facilities; - roles under a waiver declared by secretary; - emergency contact information including local police and fire stations; - methods for sharing information; and - emergency prep testing requirements. On November 1, 2023, at 11:51 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated they do not have an arrangement with another facility however have tried to make arrangements but have been unsuccessful. In addition, the EPP including missing resident was last updated sometime in 2022. LALD/LPN-D stated they did not know the EPP needed to be reviewed and/or updated yearly. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff during periods of emergency or disaster that disrupts service. In addition, the licensee would conduct a disaster drill at the facility annually and results would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 790	Continued From page 25	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and 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 the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 30, 2023, from 2:30 p.m. to 3:30 p.m., survey staff toured the facility with the licensed assisted living director/ licensed practical nurse (LALD/LPN)-D. During the tour, survey staff	0 790		

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0 790	Continued From page 26 observed both portable fire extinguishers in the facility lacked a tag or any documentation showing the required annual service date, and also lacked any tag or documentation showing the required monthly visual inspections to date. On October 30, 2023, at 3:30 p.m., LALD/LPN-D verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=C	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 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. This deficient condition had the potential to affect all staff, residents, and visitors. 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	0 800		

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0 800	Continued From page 27 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 October 30, 2023, from 10:45 a.m. to 12:30 p.m., survey staff toured the facility with the licensed assisted living director/ licensed practical nurse (LALD/LPN)-D. It was observed the upstairs bathroom had a sliding door that did not have a handle, latch, or privacy lock. The door was operated by using a hand-sized, rectangular cutout in the door. The cutout allowed clear sight lines into the bathroom when the door was in the closed position. On October 30, 2023, at 12:30 p.m., LALD/ LPN-D visually verified these deficient findings at the time of discovery. 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,	0 810		

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0 810	Continued From page 28 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements. This had the potential to affect all staff, residents, 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, 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	0 810		

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0 810	Continued From page 29 a large portion or all of the residents). The findings include: On October 30, 2023, licensed assisted living director/ licensed practical nurse (LALD/LPN)-D provided documentation on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The fire safety and evacuation plan did not provide complete actions for employees to take in the event of a fire or similar emergency and included an one instruction to evacuate without specific direction. Record review of the available documentation indicated the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents for the relocation. During interview on October 30, 2023, at 3:30 p.m., LALD/LPN-D verified that the fire safety and evacuation plan for the facility lacked these provisions.	0 810		

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0 810	Continued From page 30 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. The licensee also failed to provide fire-rated ashtrays for resident use in smoking areas. This had the potential to affect all residents, staff, and visitors. 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	0 820	This immediate correction order identified on October 30, 2023, has had the immediacy lifted as of October 31, 2023, by assigning a fire watch for the facility. This was confirmed by the licensee via email and approved by evaluation supervisor.	

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0 820	Continued From page 31 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 October 30, 2023, from 10:45 a.m. to 12:30 p.m., survey staff toured the facility with the licensed assisted living director/ licensed practical nurse (LALD/LPN)-D. At approximately 11:00 a.m., survey staff asked LALD/LPN-D to open the windows in occupied resident bedroom #1 for measurement. The window was a large bay window that had operational, casement style windows on each end. LALD/LPN-D opened the windows and measured the clear opening to be 40 inches in height and 11.5 inches in width with a total openable area of 460 square inches for both operable panes. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. At approximately 11:10 a.m., survey staff asked LALD/LPN-D to open the windows in occupied resident bedroom #2 for measurement. LALD/LPN-D opened the windows and measured the clear opening to be 18 inches in height and 27.5 inches in width with a total openable area of 495 square inches for both windows. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. At approximately 11:20 a.m., survey staff asked LALD/LPN-D to open the windows in occupied resident bedroom #3 for measurement. LALD/LPN-D opened the first and second	0 820		

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0 820	Continued From page 32 windows and measured the clear opening to be 18.25 inches in height and 26.25 inches in width with a total openable area of 479 square inches for both windows. LALD/LPN-D opened the third window and measured the clear opening to be 17.5 inches in height and 30.25 inches in width with a total openable area of 529 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. At approximately 11:30 a.m., survey staff asked LALD/LPN-D to open the windows in occupied resident bedroom #4 for measurement. LALD/LPN-D opened the window and measured the clear opening to be 36 inches in height and 17.25 inches in width with a total openable area of 621 square inches. The window did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. Survey staff explained to LALD/LPN-D that at least one window in each bedroom in a state licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD/LPN-D verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On October 30, 2023, at approximately 12:30 p.m., survey staff explained to LALD/LPN-D that an immediate correction order was issued for the above finding. LALD/LPN-D acknowledged the	0 820		

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0 820	Continued From page 33 above finding. On the same facility tour, survey staff observed that the back wooden deck was being used as a smoking area for residents. There was a small plastic ashtray and a small metal can being used as an ashtray. LALD/LPN-D stated that residents would smoke on the deck. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts on and around the wood deck were a potential fire hazard if cigarettes were not completely extinguished before discarding them. LALD/LPN-D visually verified these deficient findings at the time of discovery. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
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	01060		

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01060	Continued From page 34 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 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 a resident's emergency relocation to the resident, legal representative, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of one resident (R3). This practice resulted in a level two violation (a	01060		

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01060	Continued From page 35 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: R3 admitted to the licensee on October 9, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's progress notes dated August 16, 2023, to August 27, 2023, indicated R3 was transferred to the hospital on August 16, 2023, due to hyperglycemia (high blood sugar) and returned to the licensee on August 27, 2023. R3's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On November 1, 2023, at 10:26 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-D stated if a resident needed to relocate, the hospital or case manager would manage the situation. LALD-D/LPN-D stated they had not initiated a notice for any hospitalizations or contacted OOLTC for any resident out of the facility for over four days in a hospital or transitional care unit. In addition, LALD/LPN-D stated they were unaware of the requirement.	01060		

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01060	Continued From page 36 On November 1, 2023, at 10:56 a.m., clinical nurse supervisor (CNS)-C stated they were unaware of the requirement. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, read, "In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to Bright Path Homes within four (4) days, the Office of Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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	01500		

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01500	Continued From page 37 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), 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	01500		

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01500	Continued From page 38 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 observation, interview, and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (business office coordinator/housing manager (BOC/HM)-B). 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: BOC/HM-B was hired on October 25, 2020, to provide direct services to the residents and assist in management of the licensee's employee records, and to provide oversite of the licensee's staff and residents. On November 1, 2023, at approximately 8:30 a.m., the surveyor observed BOC/HM-B prepare and serve breakfast for residents who resided in the facility. BOC/HM-B's employee record lacked the following required annual trainings:	01500		

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01500	Continued From page 39 - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On October 30, 2023, at 2:28 p.m., BOC/HM-B stated the licensee did not provide the required training listed above to any of the employees annually. BOC/HM-B stated employees received the training topic listed above during orientation and they did not know it was a requirement to train all employees on the topic annually. On November 1, 2023, at 11:00a.m., clinical nurse supervisor (CNS)-C and licensed assisted living director/licensed practical nurse (LALD/LPN)-D both stated they were unaware that the topic list above was required annually. The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff providing assisted living services would complete at least eight hours of education for every twelve months of employment. In addition, education topics would include but not be limited to a review of the organization's policies and procedures related to provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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	01620		

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01620	Continued From page 40 after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a change of condition reassessment when a resident presented with new or changed symptoms for one of one resident (R1) and failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (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	01620	Based on observation, interview, and record review, the licensee failed to complete a change of condition reassessment when a resident presented with new or changed symptoms for one of one resident (R1) and failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment 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	

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01620	Continued From page 41 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: ONGOING ASSESSMENT R1 admitted to licensee October 9, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2001. R1's diagnoses included diabetes mellitus type 2 (DM2), hypertension (HTN), Amyotrophic Lateral Sclerosis (ALS) (a disease affecting motor neurons of the spinal cord, which causes progressive weakness and atrophy of muscles), impaired mobility, urinary tract infection (UTI) associated with indwelling urethral catheter, and chronic left shoulder pain. R1's unsigned service plan dated October 30, 2023, indicated R1 received assistance with activities of daily living, blood glucose monitoring, activity assistance, medication administration, catheter care, cough assist device assistance, bathing, housekeeping, laundry, hand splint assistance, behavior management, meal assistance, positioning, safety checks, toileting, and wheelchair use. R1's record included 90-day nursing assessments dated May 1, 2023, July 31, 2023, and October 30, 2023. The assessment completed on July 31, 2023, indicated 91 days had passed since the previous assessment completed on May 1, 2023. The assessment completed on October 30, 2023, indicated 91 days had passed since the previous assessment	01620	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 R1 admitted to licensee October 9. 2020, and started receiving assisted living services. R1's diagnoses included diabetes mellitus type 2, HTN, Amyotrophic Lateral Sclerosis (ALS), impaired mobility, UTI associated with indwelling urethral catheter and chronic left shoulder pain. R1's unsigned service plan dated October 30, 2023, indicated R1 received assistance with activities of daily living, blood glucose monitoring, activity assistance, medication administration, catheter care, cough assist device assistance, bathing, housekeeping, laundry, hand splint assistance, behavior management, meal assistance, positioning, safety checks, toileting, and wheelchair use. R1's record included 90-day nursing assessments dated May 1, 2023, July 31, 2023, and October 30, 2023. The assessment completed on July 31, 2023, indicated 91 days had passed since the previous assessment completed on May	

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01620	Continued From page 42 completed on July 31, 2023. On October 30, 2023, during the entrance conference, clinical nurse supervisor (CNS)-C stated, "the RN will complete an assessment on move-in to include physical and psychosocial aspects and then will repeat the assessment at 14 days, 30 days, and every 90 days." The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident assessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. CHANGE OF CONDITION/ACCURATE ASSESSMENTS R1's record included 90-day nursing assessments dated May 1, 2023, July 31, 2023, and October 30, 2023, and indicated R1 had a diabetic blister on the right heel. On October 31, 2023, at 8:20 am., the surveyor and unlicensed personnel (ULP)-F observed no blister or wound on R1's right or left heel. ULP-F stated they did not recall seeing a wound or blister on R1's heel previously. The surveyor inquired when they last saw a wound or blister on R1's right heel. ULP-F stated they had been on a vacation for two weeks however, there was no wound or blister on R1's right heel prior to the vacation and they did not remember ever seeing a wound or blister on R1's right heel. On November 1, 2023, at 11:30 am., CNS-C stated R1's condition fluctuates and there have been no significant changes in condition. CNS-C stated that R1's right heel blister had healed, and R1 had a left lower quadrant skin issue that healed as well. In addition, CNS-C stated they	01620	1, 2023. The assessment completed on October 30, 2023, indicated 91 days had passed since the previous assessment completed on July 31, 2023. R1's record included 90-day nursing assessments dated May 1, 2023, July 31, 2023, and October 30, 2023. All three assessments indicated the presence of a diabetic blister on the right heel. On October 31, 2023, unlicensed personnel (ULP)-F assisted the surveyors with an examination of both R1's heels and no blister or wound was found to be present. ULP-F stated he did not recall a wound or blister on either heel of R1. During the entrance conference on October 30, 2023, clinical nurse supervisor (CNS)-C stated, "the RN will complete an assessment on move-in to include physical and psychosocial aspects and then will repeat the assessment at 14 days, 30 days and every 90 days". On November 1, 2023, CNS-C stated "R1's condition fluctuates and there have been no changes in condition. Right heel blister has healed and left lower quadrant skin issue has healed as well". The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident assessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment.	

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01620	Continued From page 43 believed they made a progress note related the wounds healing and they "thought" they had updated the nursing assessment to reflect the change. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing resident monitoring must be conducted as needed based on changes in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620	No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.	01640		

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01640	Continued From page 44 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided 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, 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: R1 R1 admitted to licensee on October 9, 2020, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's diagnoses included diabetes mellitus type 2, hypertension (HTN), Amyotrophic Lateral Sclerosis (ALS) (a disease affecting motor neurons of the spinal cord, which caused progressive weakness and atrophy of muscles), impaired mobility, urinary tract infection (UTI) associated with indwelling urethral catheter, and chronic left shoulder pain.	01640	Based on interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided 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, 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: R1 R1 admitted to licensee on October 9, 2020, and began receiving assisted living services. R1's signed Service Plan (Waiver) - Addendum to Contract dated August 9, 2021, indicated R1 received 27 different services. R1's unsigned Service Plan Waiver dated October 30, 2023, indicated R1 received	

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01640	Continued From page 45 R1's signed Service Plan (Waiver) - Addendum to Contract dated August 9, 2021, indicated R1 received assistance with activity assistance three times per day, appointment reminders, bathing assistance, catheter care, dressing, grooming, housekeeping, behavior management, meal assistance, medication administration, positioning/re-positioning, safety checks, toileting, wheelchair use, vital signs, and blood glucose monitoring. R1's unsigned Service Plan Waiver dated October 30, 2023, indicated R1 received assistance with appointment assistance, dressing, grooming, blood glucose monitoring, activity assistance twice per day, medication administration, catheter care, cough assist device assistance, bathing, housekeeping, laundry, hand splint assistance, behavior management, meals, positioning, safety checks, toileting, and wheelchair use. R2 R2 admitted to licensee on May 22, 2021, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnoses included cerebrovascular accident (CVA) (stroke), major depression, and chronic pain. R2's signed Service Plan (Waiver) - Addendum to Contract dated August 9, 2021, indicated R2 received assistance with ambulation, appointment assistance, bathing assistance, dressing, grooming, housekeeping, incontinence care, meal assistance six times per day, medication administration three times per day, position/re-positioning, blood glucose monitoring	01640	33 different services. R1's service plan dated October 30, 2023, lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided. R2 R2 admitted to licensee on May 22, 2021, and began receiving assisted living services, R2's signed Service Plan (Waiver) - Addendum to Contract dated August 9, 2021, indicated R2 received 15 different services. R2's unsigned Service Plan (Waiver) - Addendum to Contract dated October 31, 2023, indicated R2 received 24 different services. R2's Service Plan dated October 31, 2023, lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided. R3 R3 admitted to licensee on October 9, 2019, and began receiving assisted living services. R3's signed Service Plan (Waiver) - Addendum to Contract dated August 9. 2021, indicated R3 received 26 different services.	

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01640	Continued From page 46 three times per day, shopping assistance, toileting, and transportation set-up. R2's unsigned Service Plan (Waiver) - Addendum to Contract dated October 31, 2023, indicated R2 received assistance with blood glucose monitoring once per day, ambulation, appointment assistance, bathing, dressing, grooming, housekeeping, incontinence care, behavior management, meal assistance five times per day, medication administration twice per day, position/repositioning, shopping assistance, toileting, and transportation set-up. R3 R3 admitted to licensee on October 9, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's diagnoses included chronic kidney disease, CVA, benign prostatic hyperplasia, diabetes type 2 (DM2), major depressive disorder, HTN, vascular dementia, and muscle weakness. R3's signed Service Plan (Waiver) - Addendum to Contract dated August 9. 2021, indicated R3 received assistance with activity assistance, appointment assistance, bathing, dressing, grooming, housekeeping, incontinence care six times per day, behavior management, meal assistance eight times per day, medication administration eight times per day, position/re-positioning, shopping assistance, transfer assistance six times per day, transportation set-up, blood glucose monitoring, wheelchair mobility, blood pressure, and temperature R3's unsigned Service Plan (Waiver) - Addendum	01640	R3's unsigned Service Plan (Waiver) - Addendum to Contract dated October 31, 2023, indicated R3 received 27 different services. R3's Service Plan (Waiver) - Addendum to Contract dated October 31, 2023 lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided. On November 1, 2023, clinical nurse supervisor (CNS)-C stated that "service plans are reviewed page by page with resident or family before signature" and "if service plans are updated, they are presented to family or resident for signature". The licensee's Service Plan policy dated August 1, 2021, read, "The initial service plan and any revisions are signed by a representative from Butterfly Bound Care and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	

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01640	Continued From page 47 to Contract dated October 31, 2023, indicated R3 received assistance with activity assistance, blood glucose monitoring, appointment assistance, bathing, dressing, grooming, housekeeping, incontinence care four times per day, behavior management, medication administration four times per day, position/re-positioning, shopping assistance, transfer assistance three times per day, transportation set-up, wheelchair mobility, blood pressure, and temperature. R1, R2, and R3's service plans lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. On November 1, 2023, at 11:00 am., clinical nurse supervisor (CNS)-C stated when a service plan was updated, they were reviewed with the resident and/or family and presented to the resident and/or family for signature. In addition, CNS-C stated they were unaware a signature was required with frequency changes to the service plan. The licensee's Service Plan policy dated August 1, 2021, read, "The initial service plan and any revisions are signed by a representative from Butterfly Bound Care and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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01730	Continued From page 48	01730		
01730 SS=F	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; (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.	01730		

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01730	Continued From page 49 (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 each resident to include all required content 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, 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 admitted to the licensee on October 9, 2020, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R1's Service Plan (Wavier)-Addendum to Contract signed August 9, 2021, indicated R1 received assistance with activities, appointments, bathing, catheter care, dressing, grooming, housekeeping, behavior management, meals, medication administration, daily vital signs, blood glucose, toileting, and mobility with wheelchair. R1's Med Admin Summary - Month (derived from	01730		

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01730	Continued From page 50 the electronic medication administration record (EMAR)) dated October 1, 2023, through October 31, 2023, included triamcinolone ointment 0.5 percent (%) 15 grams (g) apply one application to skin two times per day. The document lacked specific resident instructions on where to apply the ointment. R1's record did not contain a specific document titled medication management plan, rather, the medication management plan was comprised of multiple records, however none of the records contained specific resident instructions relating to the administration of R1's ointment. R2 R2 admitted to the licensee on August 9, 2021, and began receiving assisted living services. R2's Service Plan (Wavier)-Addendum to Contract signed August 13, 2021, indicated R2 received assistance with ambulation, appointments, bathing, dressing, grooming, housekeeping, toileting, meals, medication administration, positioning, blood glucose, shopping, and transportation. R2's Med Admin Summary - Month dated October 1, 2023, through October 31, 2023, included acetaminophen give one to two tablets every four hours as needed (PRN) for pain, Calmoseptine ointment apply topically three times per day PRN, and fluticasone 50 micrograms (mcg) nasal spray place one to two sprays in each nostril daily. The document lacked specific resident instruction on the following: - acetaminophen lacked a dosage and when R2 would receive one tablet vs two tablets; - Calmoseptine lacked a location of application; - fluticasone lacked when R2 would receive one	01730		

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01730	Continued From page 51 spray vs two sprays to the nostrils. In addition, the document indicated R2's Victoza and Basaglar subcutaneous injections were administered by an unlicensed personnel (ULP) 29 days in the month of October. R2's 90-day assessment dated September 11, 2023, indicated medication management tasks that may be delegated to ULP included nasal and oral medications. R2's record did not contain a specific document titled medication management plan, rather, the medication management plan was comprised of multiple records, however none of the records contained specific resident instructions relating to the administration of R2's subcutaneous injections. R2's medication management plan lacked the following: - specific resident instructions relating to the administration of medications; and - medication management tasks that may be delegated to ULP. R3 R3 admitted to the licensee on October 9, 2019, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R3's Service Plan (Wavier)-Addendum to contract signed August 9, 2021, indicated R3 received assistance with activities, appointments, bathing, dressing, grooming, housekeeping, toileting, behavior management, meals, medication administration, positioning, blood glucose, transfers, and transportation. R3's Med Admin Summary - Month dated October 1, 2023, through October 31, 2023,	01730		

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01730	Continued From page 52 included Ativan 0.5 mg take one to two tablets by mouth every Tuesday, Thursday, and Sunday 30 minutes prior to dialysis. The document lacked specific resident instruction on when R2 would receive 0.5 mg vs 1 mg of Ativan. R3's Individualized Medication Management Plan document dated September 20, 2023, included monitoring of medications and supplies. R3's medication management plan, nor other records contained the following: - medication management services provided by nurse and unlicensed personnel; - specific written instructions for resident medication administration; - type of medication storage system, based on resident's needs; - procedures for staff to notify an registered nurse (RN) when a problem arose; and - medication management tasks that may be delegated to ULP. On November 1, 2023, at 11:12 a.m., clinical nurse supervisor (CNS)-C stated resident specific instructions for medication administration would be located on the EMAR. In addition, CNS-C stated items listed above were missed however, if the ULP had questions regarding the medication they could contact the nurse for instructions. The licensee's Service Plan for Medication Management policy dated August 1, 2021, read, " 1. The written Medication Management Plan includes the following provisions. a. A statement describing the medication management services to be provided b. A description of the storage of medications based on the resident assessment* and addressing i. Resident preference	01730		

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01730	Continued From page 53 ii. Risk of diversion iii. Instructions per manufacturer c. Documentation procedures d. Procedures for medication reconciliation* e. Identification of person(s) responsible for monitoring medication supplies and ensuring refills are ordered/timely f. Description of medication management tasks to be delegated to unlicensed personnel g. Plans for staff notifying the licensed health professional when/if a problem with medication management services arises h. Any resident-specific requirements related to documenting medication administration, verification that all medications are administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 54 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately in the electronic medication administration record (EMAR) for two of two residents (R1, R2). In addition, the licensee failed to ensure unlicensed personnel ((ULP)-A, ULP-E) followed appropriate medication administration procedures for two of two residents (R1, 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 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 admitted to the licensee on October 9, 2020, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R1's diagnoses included diabetes mellitus type 2 (DM2), hypertension (HTN), mild intellectual disability, mild intermittent asthma, major depressive disorder, cognitive disorder, amyotrophic lateral sclerosis (ALS) (a disease affecting motor neurons of the spinal cord, which caused progressive weakness and atrophy of	01760		

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01760	Continued From page 55 muscles), and prostate cancer. R1's Service Plan (Wavier)-Addendum to Contract signed August 9, 2021, indicated R1 received assistance with activities, appointments, bathing, catheter care, dressing, grooming, housekeeping, behavior management, meals, medication administration, daily vital signs, blood glucose, toileting, and mobility with wheelchair. On October 31, 2023, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-A enter R1's room without the laptop used to review and document medication administration (via electronic medication administration record (EMAR)). ULP-A opened R1's locked medication cabinet, retrieved a multidose blister pack which contained vitamin D 50 microgram (mcg), omeprazole 20 milligram (mg), aspirin 81 mg, metformin 1000 mg, acyclovir 400 mg, hydroxyzine, senna S 8.6 mg /50 mg, risperidone 1 mg, acetaminophen 325 mg, gabapentin 300mg, and riluzole 50 mg, and ULP-A retrieved a second a second single dose blister card that contained hydrochlorothiazide (HCTZ) 12.5 mg. ULP-A opened and emptied the multidose blister packet and the one single dose blister card into a medication cup, exited R1's room to retrieve apple sauce, re-entered the room, placed apple sauce into the medication cup, and administered the medications to R1. The surveyor did not observe ULP-A verify a medication count (number of pills) or verifiy the medications against the written orders in the EMAR prior to administration. After the medication administration, ULP-A assisted R1 to eat breakfast and cleaned R1's room. ULP-A documented R1's medication administration later at 10:52 a.m.	01760		

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01760	Continued From page 56 On October 31, 2023, at 1:05 p.m., the surveyor received a printed copy of R1's EMAR from business office coordinator/housing manager (BOC/HM)-B which indicated ULP-A documented they had administered the following medications in addition to the medications listed above. The surveyor did not oberve ULP-A administer to R1: - Guaifenesin 600 mg; - losartan 50 mg; - metoprolol 50 mg; and - Miralax 17 gm. On October 31, 2023, at 10:27 a.m., ULP-A stated they were trained and had a competency evaluation on medication administration completed by a registered nurse (RN). ULP-A stated they were trained to use the seven rights of medication administration by checking the name of person, name of medication, dosage, and route. The surveyor inquired how they checked for the information listed above. ULP-A stated, "so look at the MAR (medication administration record) and check what medication is supposed to be passed in the morning and compare before giving proper medication and dosage." The surveyor inquired when ULP should document on medication administration. ULP-A stated they document on medication administration after all cares were completed. R2 R2 admitted to the licensee on August 9, 2021, and began receiving assisted living services. R2's diagnoses included cerebrovascular accident (stroke), major depression, and chronic pain. R2's Service Plan (Wavier)-Addendum to Contract signed August 13, 2021, indicated R2	01760		

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01760	Continued From page 57 received assistance with ambulation, appointments, bathing, dressing, grooming, housekeeping, toileting, meals, medication administration, positioning, blood glucose, shopping, and transportation. On October 31, 2023, at 8:11 a.m., the surveyor observed ULP-E enter R2's room without the laptop. The surveyor observed ULP-E open R2's medication cabinet, retrieve a multidose blister packet which contained Januvia 100 mg and clopidogrel 75 mg, open and empty the blister packet into a medication cup, and administer the medications to R2. The surveyor did not observe ULP-E verify a medication count or verify the medications against the written orders in the EMAR prior to administration. ULP-E then assisted with meal preparation and completed progress notes on each of the four residents in the facility, and did not immediately document the medication administration in R2's EMAR. On October 31, 2023, at 9:01 a.m., ULP-E stated they were trained and received a competency on medication administration with the RN and stated they did not pass medication often. The surveyor inquired how the ULP was trained to complete medication administration. ULP-E stated, "because meds are already set up, we just take them at the time scheduled out of the pouch and administer to the clients." The surveyor inquired how the ULP were trained to completed medication administration documentation. ULP-E stated if they administered an as needed (PRN) medication they would document in the EMAR and follow up on the effectiveness in one hour. The surveyor inquired why ULP-E did not document on the medication given at 8:11 a.m., on October 31, 2023. ULP-E stated because they were an overnight employee who was asked to	01760		

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01760	Continued From page 58 stay late due to the late arrival of the day shift employee, they did not normally administer the morning medications. ULP-E stated the medications they administered showed up on the EMAR task list for the day shift to document and did not show on the overnight staff task list for verification or charting. ULP-E stated they would share the information that they administered R2's morning medications with the incoming ULP during shift report so the medications would not be given twice and so the day shift ULP could document the medications as having been administered. On October 31, 2023, at 9:36 a.m., as ULP-E was leaving the facility for the day, ULP-E approached surveyor and stated they documented in RTasks (a documenting software program) that they provided R2 with the medications observed as administered above. On October 31, 2023, at 1:00 p.m., the surveyor again observed R1's medication cabinet which contained insulins, multiple single dose blister cards, multiple multidose blister packets, and multiple medication bottles. The surveyor also R2's medication cabinet contained nasal sprays, multiple multidose blister packets, and multiple medication bottles. The ULP's demonstrated practice of administering medications without use of the EMAR along with the multiple medication packaging options was a contibuting factor in the medication documentation error for R1. On November 1, 2023, at 11:17 a.m., clinical nurse supervisor (CNS)-C stated all ULP received a training and competency evaluation on medication administration on all routes. CNS-C stated they trained on what medications each resident received and which medications	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32914	A. BUILDING: _____ B. WING _____	11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	6207 CHOWEN AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 59 residents should not to take on certain days. CNS-C stated the multidose blister packets list the day and time the medication needs to be taken and what medications are included in the packet, "they just need to read it". In addition, CNS-C stated licensed assisted living director/licensed practical nurse (LALD/LPN)-D and CNS-C verify the medications in the multidose blister packet match the provider orders before placing them into the resident's room. CNS-C stated staff have "a couple hours" to document medication administration however, when they document they should change the time to the exact time it was given. LALD/LPN-D stated RTasks gives ULP a four-hour window to document. The licensee's Medication Documentation policy dated August 1, 2021, indicated each medication administered by the licensee would be document in the clinical record and documentation would be complete, accurate, and legible. The licensee's Medication Administration policy dated August 1, 2021, indicated the registered nurse (RN) had prepared written instructions for the ULP in the proper methods to administer the medications with respect to each resident. In addition, all staff with responsibility for medication administration would have access to information about the medication being administered including but not limited to: - purpose; - dosage; - route; - frequency; - instructions related to the medication and specific to the residents, as appropriate; - side effects; and - resident allergies to medications.	01760		

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01760	Continued From page 60 The policy lacked a procedure for how the ULP would verify or receive the information listed above. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location 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, 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 admitted to the licensee on October 9, 2020, under the licensee's former comprehensive	01880		

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01880	Continued From page 61 license and began receiving assisted living services August 1, 2021. R1's diagnoses included diabetes mellitus type 2 (DM2), hypertension (HTN), mild intellectual disability, mild intermittent asthma, major depressive disorder, cognitive disorder, amyotrophic lateral sclerosis (ALS) (a disease affecting motor neurons of the spinal cord, which caused progressive weakness and atrophy of muscles), and prostate cancer. R1's Service Plan (Wavier)-Addendum to Contract signed August 9, 2021, indicated R1 received assistance with activities, appointments, bathing, catheter care, dressing, grooming, housekeeping, behavior management, meals, medication administration, daily vital signs, blood glucose, toileting, and mobility with wheelchair. R1's ongoing assessment dated July 31, 2023, indicated R1 required total assist with medication administration and medications were stored and locked up. R2 R2 admitted to the licensee on August 9, 2021, and began receiving assisted living services. R2's diagnoses included cerebrovascular accident (stroke), major depression, and chronic pain. R2's Service Plan (Wavier)-Addendum to Contract signed August 13, 2021, indicated R2 received assistance with ambulation, appointments, bathing, dressing, grooming, housekeeping, toileting, meals, medication administration, positioning, blood glucose, shopping, and transportation.	01880		

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	32914	A. BUILDING: _____ B. WING _____	11/01/2023

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01880	Continued From page 62 R2's ongoing assessment dated September 11, 2023, indicated R2's medications were stored and locked and R2 required total assist to administer medications. R3 R3 admitted to the licensee on October 9, 2019, under the licensee's former comprehensive license and began receiving assisted living services August 1, 2021. R3's diagnoses included chronic kidney disease stage five, edema, antisocial personality disorder, cerebral infarction (brain lesion in which a cluster of brain cells die when they don't get enough blood), major depressive disorder, vascular dementia, alcohol induced disorder, and dysphasia. R3's Service Plan (Wavier)-Addendum to contract signed August 9, 2021, indicated R3 received assistance with activities, appointments, bathing, dressing, grooming, housekeeping, toileting, behavior management, meals, medication administration, positioning, blood glucose, transfers, and transportation. R3's Individualized Medication Management Plan dated September 20, 2023, indicated R3 was unable to self-administer medications. On October 30, 2023, at 10:43 a.m., during facility tour, the surveyor observed the following medication unsecured: - R1's bedroom: one Basaglar KwikPen, Victoza injection pen, and two Refresh Lubricants eye ointments; - R2's bedroom: one bottle of fluticasone 50 microgram (mcg) spray; and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01880	Continued From page 63 - R3's bedroom: one insulin aspart flex pen, one Basaglar KwikPen, one bottle of miconazole powder 2 percent (%). On October 31, 2023, at 9:34 a.m., during facility tour, the surveyor observed the following medication unsecured in R2's room: - one bottle of fluticasone 50 mcg spray; and - one pill of atorvastatin calcium 20 milligrams (mg). On November 1, 2023, at 11:30 a.m., clinical nurse supervisor (CNS)-C stated all resident medications were stored in the resident room in a locked cabinet and ULP were trained to store medications in the locked cabinets. CNS-C stated they weree unaware of why medications were unsecured for R1, R2, and R3. The Storage/Control of Medications policy dated August 1, 2021, indicated medications were stored in a secured medication cabinet and only authorized nursing personnel have access to the locked cabinet. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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.	01890		

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01890	Continued From page 64 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of 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, 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: On October 31, 2023, at 1 :00 p.m., during facility tour, the surveyor observed R1, R2, and R3's medication cabinets that unlicensed personnel (ULP) used for medication administration, located in resident's rooms, and observed the following expired medications: - R1: two cards of trazodone 50 milligrams (mg) with and expiration date of June 8, 2023, and February 10, 2023, one card of clonidine hydrochloride (hcl) 0.1 mg with an expiration date of December 6, 2022; - R2: one bottle of acetaminophen 500 mg with an expiration date of April 2022; and - R3: one card of metoclopramide 10 mg with and expiration date of July 3, 2023. On October 31, 2023, at 1:11 p.m., ULP-A stated if they found a medication expired in the medication cabinet, they notify a nurse, and the nurse would dispose the medication.	01890		

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01890	Continued From page 65 On November 1, 2023, at 11:31 a.m., clinical nurse supervisor (CNS)-C stated they trained ULP to notify a nurse if there is an expired medication and not to administer the medication to the resident. The surveyor inquired why R1, R2, and R3's medication cabinets contained expired medication. CNS-C stated it may have been an oversite. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated discontinued medication would be kept until the expiration dates if there was a possibility of resuming the medication and if not resumed before the expiration date it would be disposed of according to the policy. No further information 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 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	01940		

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01940	Continued From page 66 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, 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 three residents (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 admitted to the licensee on October 9, 2020, under the licensee's former comprehensive	01940		

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01940	Continued From page 67 license and began receiving assisted living services August 1, 2021. R1's diagnoses included diabetes mellitus type 2 (DM2), hypertension (HTN), mild intellectual disability, mild intermittent asthma, major depressive disorder, cognitive disorder, amyotrophic lateral sclerosis (ALS) (a disease affecting motor neurons of the spinal cord, which caused progressive weakness and atrophy of muscles), and prostate cancer. R1's unsigned Service Plan (Wavier)-Addendum to Contract dated October 31, 2023, indicated R1 received assistance with blood glucose monitoring, activities, appointments, bathing, catheter care, cough assist device, dressing, grooming, hand split, housekeeping, behavior management, meals, medication administration, vital signs, toileting, and mobility with wheelchair. On October 31, 2023, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-A use the cough assist machine on R1. On November 1, 2023, 8:15 a.m., the surveyor observed ULP-F complete blood glucose monitoring on R1. R1's provider orders signed April 12, 2023, included cough assist device daily, hand split to the left hand two times daily, blood glucose twice per day. R1's treatment administration record (derived from RTasks, a documenting software program) dated October 31, 2023, included cough assist device assist client to clear phlegm in the throat estimated time 10 minutes, hand splint apply hand splint to the left-hand estimated time 10	01940		

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01940	Continued From page 68 minutes, and blood glucose tell resident what you are going to do and then wipe area with a cotton ball. R1's individualized treatment management plan lacked the following required content: - written instructions for each treatment or therapy related to the cough assist machine; and - procedures to notify a registered nurse (RN) or other licensed health professional when problems arose with treatment or therapies. On November 1, 2023, at 11:33 a.m., clinical nurse supervisor (CNS)-C stated the treatment management plan would be located in RTasks and it would have when a treatment would be performed, instructions related to the treatment. In addition, CNS-C stated they did not know there needed to be specific instructions related to the cough assist machine since they trained all ULP on the device. The licensee's Treatment and Therapy Management policy dated August 1, 2021, read, "The RN or licensed professional will prepare and individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided. b. Procedures for documenting treatment therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel. e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service."	01940		

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01940	Continued From page 69 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/30/23*
Time: 12:45:00
Report: 1025231239

Food and Beverage Establishment Inspection Report

Location:
Butterfly Bound Care
6207 Chowen Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038124
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7636703715
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.

3-100 Food Characteristics: unadulterated

3-101.11 ***** Priority 1 *****

MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.

Remove opened unsealed food from the premises, opened bags of rice, oatmeal, cereal provided to staff for discard.

Corrected on Site

7-200 Toxic Supplies and Applications

7-202.12AB ***** Priority 1 *****

MN Rule 4626.1610AB Use poisonous or toxic materials according to label directions and MN Statutes chapter 18B. Application must not constitute a hazard to people and contamination of food, equipment, utensils, linens and single-use and single-service articles must be prevented.

Bleach in kitchen not labeled for "food contact surface" use (contains fragrance); provide a sanitizer labeled for food contact surface use. Use all pesticides per label directions.

Comply By: 10/30/23

4-300 Equipment Numbers and Capacities

4-301.12A ***** Priority 2 *****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

Facility provides a receptacle for sanitizing after washing in sink compartment #2, rinsing (2 compartments available, one dedicated for handwashing), and then basin used for sanitizing, and space provided for air drying.

Comply By: 12/31/23

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

3-307.11

MN Rule 4626.0337 Protect food from miscellaneous sources of contamination.

Provide sealable containers for opened food, or store in refrigerator, to provide protection from pests.

Comply By: 10/30/23

4-200 Equipment Design and Construction

4-202.17

MN Rule 4626.0545 Remove kick plates that are not designed to be easily removed for cleaning and inspection.

Enclosed hollow bases for cabinetry are prohibited in establishments; retrofit or otherwise provide cabinets without hollow enclosed bases due to pest presence.

Comply By: 11/17/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

Live German cockroaches observed during inspection, carcasses observed in cabinets, provide treatment and clean kitchen thoroughly to reduce harborage; see additional comments

Comply By: 10/30/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

Thoroughly clean the cabinets, floor, cracks, corners, seams, behind equipment, under cabinetry, etc to reduce pest harborage and increase treatment effective.

Comply By: 11/01/23

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	4

Please provide pest control invoices and photos or written confirmation of corrected violations on this report via email to [casey.kipping@state.mn.us] by the compliance dates listed for items with comply by dates in October or November by November 18 2023.

Food and ingredients often stored at facility across the street and transported to kitchen, reported covered containers used
6212 Chowen Ave N

Brooklyn Center 55429
Provide one CFPM per license/establishment

PEST CONTROL AND OTHER ITEMS
Live German cockroaches observed during inspection (cabinet beside stove, upright cabinet by refrigerator).
Reported by staff pest control treats the kitchen.
Kitchen needs to be thoroughly cleaned for treatment to be successful
Clean all surfaces in cabinets, behind equipment, under equipment, corners, floor, etc to reduce harborage
Chemicals need to be safe and appropriate for kitchen/food service/restaurant use (verify by asking chemical treatment company or chemical label if self-treated)
Provide containers for employee belongings to store items at the facility that cannot be left in personal vehicles, or for employees who walk, use transit, or other means of transportation
Staff, frequent visitors etc need to have their living spaces clean and clear of pests to avoid transporting pests back into the facility after treatment
Store all open food in sealable containers and keep sealed
Unsealed food discarded during inspection (pest present in bag of uncooked rice between refrigerator and stove)
Discussed sanitizer use (provide bleach that says "Food Contact" on the label, make sure its not scented, lavender scented bleach under sink)
Thermometer is available, chlorine test kit available, reported solution made to 100PPM
Discussed same solution can be used to sanitize counters, surfaces, handles, etc
Recommend providing several cutting boards for a food contact surface to protect laminate countertop and provide an easily cleanable food contact surface
Reported no other food or freezers in the home
Replace wood utensils - stained and/or broken utensils handed to staff for discard

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page

SINK USAGE
Facility has a two basin sink
Facility dedicates one basin for handwashing and one for warewashing (signage)
Additional basin provided for sanitizing
Facility does not have a 3 compartment sink
Facility does not have a food preparation sink
Facility does not have a stand-alone handwashing sink

FACILITY
Kitchen has wood/laminate floor, laminate countertops, wood cabinets, smooth painted ceiling, hollow enclosed cabinet bases, some tile backsplash but mostly faux brick wall
Appliances are residential
Reported medication and personal items maintained in other locations or refrigerators in resident rooms

DISHWASHING - NO DISHWASHER PRESENT
4626.0680 Alternative manual warewashing equipment that meets the requirements in parts 4626.0875 and 4626.0880 may be used when there are special cleaning needs or constraints and its use is approved by the regulatory authority. Alternative manual warewashing equipment may include:
[_] (5) receptacles that substitute for the compartments of a multicompartment sink.
https://www.nsf.org/consumer-resources/articles/dishwasher-certification

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher).
Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean but without the use of chemicals which may damage the finish. Do not use wood as a food contact surface.

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest control

Highly susceptible populations - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
"MDH Highly Susceptible Population"
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Chemical label, use, and storage
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

Type: Full
Date: *10/30/23*
Time: 12:45:00
Report: 1025231239
Butterfly Bound Care

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025231239 of 10/30/23.

Certified Food Protection Manager: Selina Birabwa

Certification Number: FM112114 Expires: 07/27/25

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231239

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

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

Date 10/30/23
Time In 12:45:00
Time Out

Butterfly Bound Care	Address: 6207 Chowen Avenue North	City/State: Brooklyn Center, MN	Zip Code: 55429	Telephone: 7636703715
License/Permit #: 0038124	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 10/30/23

Inspector (Signature) Cory King