



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 30, 2025

Licensee

Butterfly Bound Care

3207 67th Avenue North

Brooklyn Center, MN 55429

RE: Project Number(s) SL35716016

Dear Licensee:

On May 8, 2025, 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 January 24, 2025. This follow-up survey determined your facility had corrected all of the state correction orders issued pursuant to the January 24, 2025 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.

Also, at the time of this follow-up survey completed on May 8, 2025, we identified the following violation(s):

0130 - Application For Licensure - 144g.12, Subd. 1

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration

process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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,

A handwritten signature in black ink, appearing to read "Casey DeVries".

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35716	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/08/2025
NAME OF PROVIDER OR SUPPLIER BUTTERFLY BOUND CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3207 67TH 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
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL35716016-1 On May 8, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 21, 2025. At the time of the survey, there were three residents; three receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/ or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130			

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130			

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130			

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to prevent staff members from regularly sleeping at the facility in between scheduled shifts. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's Staffing Plan dated January 25, 2025, indicated the shifts were 7:00 a.m., until 7:00 p.m., and 7:00 p.m., until 7:00 a.m., and one unlicensed personnel (ULP) was scheduled to work each shift. The licensee's Work Schedule dated May 4, 2025, through May 17, 2025, indicated there was one ULP scheduled to work each shift. On May 8, 2025, at 9:16 a.m., R1 stated they had observed ULP-H at the facility on the overnight shift while ULP-F, ULP-G, ULP-I all slept at the facility every night for approximately one year.	0 130			

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0 130	Continued From page 5 On May 8, 2025, at 9:31 a.m., the surveyor observed room three on the main level of the assisted living facility. In the room was a television on a small stand and a dining chair with a jacket and a red dress over the back of the dining chair. Next to the dining chair was a nightstand that had a blender, a tub of cream cheese, a tub of Vaseline, an upside-down bottle with an unknown content, a tub of Cool Whip, two pens, and a bottle of medication containing amlodipine 5 milligram, that appeared full. Next to the nightstand was a large green bucket with a red lid, next to the bucket was a bottle of milk and a refrigerator. The refrigerator contained various containers of grains, vegetables, and a bag of salad. The bed in the room was covered with bedding. the closet contained numerous items of hung clothing, a basket full of folded clothes, a red suitcase, and a black trash bag that contained clothing. On May 8, 2025, at 9:31 a.m., ULP-H stated the personal effects in the room belonged to a previous resident. ULP-H stated while they worked during the night shift, ULP-F, ULP-G, and ULP-I had slept at the facility each night. On May 8, 2025, at 9:53 a.m., R2 stated they had observed three additional staff members at the facility at night. R2 stated they also observed the individuals sleeping on the sofas in the common area on the main level. On May 8, 2025, at 10:10 a.m., the surveyor called ULP-G and left a message for them to call back. On May 8, 2025, at 10:10 a.m., the surveyor called ULP-F and left a message for them to call	0 130			

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0 130	Continued From page 6 back. On May 8, 2025, at 10:21 a.m., ULP-H stated the medications in room three belonged to their sister and they had picked them up from the pharmacy. On May 8, 2025, at 11:05 a.m., agent/licensed practical nurse/licensed assisted living director (A/LPN/LALD)-D stated only one ULP was scheduled to be at the facility each night. A/LPN/LALD-D stated only residents and scheduled staff members were allowed to be at the facility. A/LPN/LALD-D stated they were unsure why residents and staff were telling the surveyor that staff were staying at the facility when they were not scheduled to work. A/LPN/LALD-D stated they were unaware other staff members were sleeping at the facility, and they would address the situation with staff. On May 8, 2025, at 11:25 a.m., the surveyor concluded the survey. At the close of the survey, the surveyor did not receive a response back from ULP-F or ULP-G. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130			
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time;	{0 460}			

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{0 460}	Continued From page 7 (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by:	{0 460}	Not reviewed during this survey.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated	{0 480}			

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{0 480}	Continued From page 8 correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
			Not reviewed during this survey.		

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{0 500}	Continued From page 9	{0 500}			
{0 500} SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and 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; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) 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; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or	{0 500}			

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{0 500}	Continued From page 10 licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by:	{0 500}	Not reviewed during this survey.		
{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 working on site. (c) The facility must meet any additional requirements adopted in rule.	{0 680}			

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{0 680}	Continued From page 11 This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{0 700} SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	{0 700}			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}			
{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	{0 810}			

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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
{0 810}	Continued From page 12 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by:	{0 810}	Not reviewed during this survey.		
{01370} SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services	{01370}			

Minnesota Department of Health

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{01370}	Continued From page 13 provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}	Not reviewed during this survey.		

Minnesota Department of Health

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{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this survey.		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service	{01650}			

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{01650}	Continued From page 15 cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}	Not reviewed during this survey.		
{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	{01730}			

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{01730}	Continued From page 16 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	{01730}	Not reviewed during this survey.		
{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	{01760}			

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{01760}	Continued From page 17 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:	{01760}	Not reviewed during this survey.		
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	{01820}			
{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:	{01880}			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments	{01960}			

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{01960}	Continued From page 18 Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}	Not reviewed during this survey.		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	{01970}			
{02290} SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights	{02290}			

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{02290}	Continued From page 19 at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by:	{02290}	Not reviewed during this survey.		
{02320} SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	{02320}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 3, 2025

Licensee
Butterfly Bound Care
3207 67th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL35716016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 24, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 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.

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

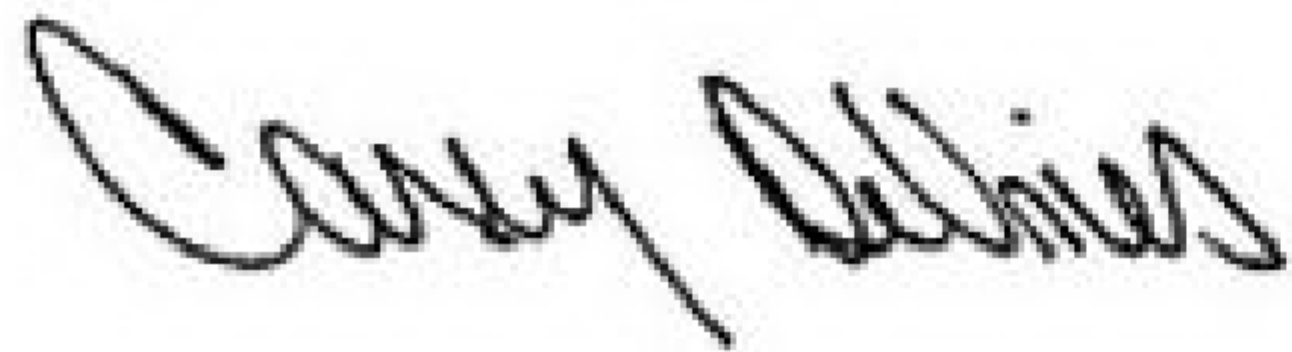
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries".

Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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0 000	Initial Comments 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: SL351716016-0 On January 21, 2025, through January 24, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two resident(s); two receiving services under the Assisted Living Facility license. An immediate order for correction was identified on January 21, 2025, issued for SL351716016-0, tag identification 0495. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate order for correction was identified on January 22, 2025, issued for SL351716016-0, tag identification 2310. During the survey, the licensee took action to	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1	0 000			
0 460 SS=F	mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. 144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive	0 460			

Minnesota Department of Health

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0 460	Continued From page 2 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On January 21, 2025, at 10:59 a.m., during a facility tour, the surveyor observed a split-level home and did not observe call lights, call pendants, or bells located in the rooms of the residents or in the common areas. On January 23, 2025, at 2:20 p.m., agent/licensed practical nurse/licensed assisted living director (A/LPN/LALD)-D stated the call light system was removed from the facility as R1 complained about the alarm causing distress. A/LPN/LALD-D stated they would obtain a new call light system for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the	0 480			

Minnesota Department of Health

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0 480	Continued From page 3 CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480			

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0 480	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 22, 2025, 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			
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by:	0 495			

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0 495	Continued From page 5 Based on observation, interview, and record review, the licensee failed to provide staff access to a registered nurse (RN) twenty-four (24) hours per day, seven (7) days per week. This had the potential to affect all residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included schizophrenia (a mental disorder where the person hears and sees things that are not real), hypertension, high cholesterol, general anxiety disorder, diabetes type 2 (problems with regulating blood sugar levels), panic attacks, and depression. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received services including assistance with activity, bathing, bedmaking, deep room cleaning, grooming, housing keeping, linen exchange, behavior management, meals, medication administration, vital sign recording, garbage removal, and toileting. R2 R2's diagnoses included post-traumatic disorder, mild persistent asthma (when the lungs become inflamed making breathing hard), insomnia, generalized anxiety disorder, hypertension (high	0 495			

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0 495	Continued From page 6 blood pressure), overweight, irritable bowel syndrome (digestive disorder that causes abdominal pain, bloating, diarrhea, and constipation), depressive disorder (condition that involves a depressed mood and loss of interest in activities), ulnar neuropathy of left upper extremity (nerve damage to the upper left arm), anal fissure (opening in the anal passage), and rectal spasm. R2's Service Plan - Waiver effective date January 1, 2025, indicated R2 received services including assistance with housekeeping, laundry, behavior management, shopping, and reminders for medication, bathing, dressing, and grooming. On January 21, 2025, at 9:55 a.m., licensed practice nurse/licensed assisted living director (LPN/LALD)-D stated clinical nurse supervisor (CNS)-C was leaving for an out of country trip that day, January 21, 2025, for a 24-hour period. LPN/LALD-D stated they did not have another RN available for consult during the time CNS-C would be unavailable. On January 21, 2025, at 10:24 a.m., CNS-C stated they were leaving for an out of country trip later that day, and there was no additional RN available to provide coverage while traveling. On January 21, 2025, at 10:51 a.m., LPN/LALD-D stated one unlicensed personnel worked from 7:00 a.m. until 7:00 p.m., and 7:00 p.m. until 7:00 a.m., the CNS was at the facility 2 to 3 times per week, and was on call 24 hours per day, 7 days per week. On January 21, 2025, at 11:59 a.m., unlicensed personnel, office manager (OM)-B stated CNS-C contacted them via phone and stated they were leaving for an out of country trip and to contact	0 495			

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0 495	Continued From page 7 LPN/LALD-D for any nursing questions. On January 21, 2025, at 12:06 p.m., LPN/LALD-D stated they were aware an LPN nursing license did not have the scope of practice to provide coverage for the RN. LPN/LALD-D stated they were going to provide coverage to the residents and would not be able to hire a RN, "right away." On January 21, 2025, at 12:59 a.m., OM-B stated they would contact LPN/LALD-D with any care related questions and had not received any further instruction from LPN/LALD-D regarding CNS-C leaving for the trip. On January 21, 2025, at 1:02 p.m., the surveyor called CNS-C inquiring about the time of the flight. CNS-C stated via phone they were boarding the flight at that time. The surveyor was able to hear airplane boarding announcements in the background. The licensee's Staffing Pattern dated January 2025, indicated there was 1 care giver per shift, and there was 1 registered nurse onsite and on-call. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated there would be a RN available either in person, buy phone, or by other means 24 per day 7 days per week. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures	0 500			

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0 500	Continued From page 8 Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and 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; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) 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; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and	0 500			

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0 500	Continued From page 9 licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, at 10:51 a.m., the surveyor emailed the licensee that an onsite assisted living facility survey would be initiated on January 21, 2025, at approximately 9:30 a.m. The email indicated the licensee's policies and procedures would need to be available for review. The licensee failed to provide the following policies and procedures during or after the survey process: -background studies. On January 23, 2025, at 3:17 p.m., office manager (OM)-B stated the licensee did not have a background study policy. On January 23, 2025, at 3:19 p.m., agent/licensed practice nurse/licensed assisted	0 500			

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0 500	Continued From page 10 living director (A/LPN/LALD)-D stated they were unaware that the licensee was required to have a background study policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500			
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 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680			

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0 680	Continued From page 11 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 dated August 25, 2022, lacked evidence of the following required content: - not annually updated; - arrangements with other facilities; - roles under a waiver declared by secretary; - long-term family notifications, and; - emergency prep testing requirements, including staff drills using the emergency preparedness plan. On January 23, 2025, at 2:38 p.m., agent/licensed practice nurse/licensed assisted living director (A/LPN/LALD)-D stated they were responsible for the EPP for the assisted living facility (ALF). A/LPN/LALD-D stated they believed the EPP contained all the required content. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated licensee would have a plan in place to assure the safety and	0 680			

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0 680	Continued From page 12 well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two resident's (R1) personal health and medical information was kept private. 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 isolated 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:	0 700			

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0 700	Continued From page 13 R1 was admitted to the facility on December 31, 2019, and began receiving assisted living services. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received assistance with medication administration. On January 21, 2025, at 10:59 a.m., during a facility tour, the surveyor observed the following notice on R1's door, "[R1] insulin changes at breakfast - inject 500 units, lunch - inject 600 units, dinner - inject 500 units, bedtime - inject 130 units." On January 23, 2025, at 10:23 a.m., registered nurse (RN)-E stated any resident medical information should not be displayed for other residents to be able to view. CNS-C stated the notice on R1's door should not be posted and was unsure why it was posted. On January 23, 2025, at 2:20 p.m., agent/licensed practice nurse/licensed assisted living director (A/LPN/LALD)-D stated all resident medical information should be kept confidential. A/LPN/LALD-D stated the notice on R1's door should not be posted and was unsure who posted that notice. The licensee's Resident Confidentiality policy dated August 1, 2021, indicated licensee would keep medical information confidential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			

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0 775	Continued From page 14	0 775			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are maintained with the same power supply as when constructed. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, from 10:45 a.m. to 12:30 p.m., on a facility tour with house manager (HM)-A, the following was observed: The smoke alarm in the lower level outside of resident room 4, and the smoke alarm inside of resident room 4 were previously hard wired and have been replaced with battery powered smoke alarms. Smoke alarms are required to be maintained as hardwired (receiving power from the building	0 775			

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0 775	Continued From page 15 electrical system) as installed at the time of construction in accordance with current Minnesota State Fire Code. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not	0 810			

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0 810	Continued From page 16 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. 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: On January 21, 2025, agent/licensed nurse practitioner/licensed assisted living director (A/LPN/LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided	0 810			

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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
0 810	Continued From page 17 FSEP was from a third-party provider and had not been updated to the specific facility. 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. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. A/LPN/LALD-D stated that employees sign a policy review statement annually. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370			

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01370	Continued From page 18 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP)-F,	01370			

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01370	Continued From page 19 ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F ULP-F was hired on October 19, 2020, to provide direct care services. ULP-F's employee record lack evidence of the following: Training: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider, and; - basic nutrition, meal preparation, food safety, and assistance with eating. Demonstration of Competency: - standby assistance techniques and how to perform them; - preparation of modified diets as ordered by a licensed health professional, and; - awareness of commonly used health technology equipment and assistive devices. ULP-G ULP-G was hired on March 8, 2021, to provide direct care services.	01370			

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01370	Continued From page 20 ULP-G's employee record lack evidence of the following: Training: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional, and; - awareness of commonly used health technology equipment and assistive devices. Demonstration of Competency: -standby assistance techniques and how to perform them. On January 23, 2024, at 2:27 p.m., clinical nurse supervisor (CNS)-C stated they were responsible for the training of staff and completing the competencies for staff members. CNS-C stated this was not a documentation error, and they were aware of the training and competency requirements. CNS-C stated they did not know why there were missing documentation of training and competencies. The licensee's Staff Competency policy dated August 1, 2022, indicated staff would receive training and complete competency in the delivery of assisted living services to include the areas noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			

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01380	Continued From page 21	01380			
01380 SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for two of three employees (unlicensed personnel (ULP)-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01380			

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01380	Continued From page 22 found to be pervasive). The findings include: ULP-F ULP-F was hired on October 19, 2020, to provide direct care services. ULP-F's employee record lack evidence of the following: Training: - observation, reporting, and documenting of resident status; and - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. Demonstration of Competency: - safe transfer techniques and ambulation; and - range of motioning and positioning. ULP-G ULP-G was hired on March 8, 2021, to provide direct care services. ULP-G's employee record lack evidence of the following: Training: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, and; - recognizing physical, emotional, cognitive, and developmental needs of the resident. Demonstration of Competency: -range of motioning and positioning.	01380			

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01380	Continued From page 23 On January 23, 2024, at 2:27 p.m., clinical nurse supervisor (CNS)-C stated they were responsible for the training of staff and completing the competencies for staff members. CNS-C stated it was not a documentation error and they were aware of the training and competency requirements. CNS-C stated they did not know why there were missing documentation of training and competencies. The licensee's Staff Competency policy dated August 1, 2022, indicated staff would receive training and complete competency in the delivery of assisted living services to include the areas noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650			

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01650	Continued From page 24 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include required service plan content 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), 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 was admitted to the facility on December 31, 2019, and began receiving assisted living services. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received assistance with activity assistance,	01650			

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01650	Continued From page 25 bathing assistance, bedmaking, deep room cleaning, grooming, housing keeping, linen exchange, behavior management, meal assistance, medication administration, vital sign recording, garbage removal, and toileting. R1's service plan lacked the following required content: - a contingency plan that included: the action to be taken if the scheduled service cannot be provided, information and a method to contact the facility, and; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. R2 R2 was admitted to the facility on December 31, 2024, and began receiving assisted living services. R2 Service Plan - Waiver effective date January 1, 2025, indicated R2 received assistance with bathing reminder, dressing reminder, grooming reminder, housekeeping, laundry, behavior management, medication reminder, and shopping assistance. R2's service plan lacked the following required content: - a contingency plan that included: the action to be taken if the scheduled service cannot be provided, information and a method to contact the facility, and; the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On January 23, 2025, at 1:48 p.m., clinical nurse	01650			

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01650	Continued From page 26 supervisor (CNS)-C stated they were surprised to learn there was missing content from the service plans. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include, " 8. The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party b. The fees for services and the frequency of each service, according to the resident's current review or assessment and resident preferences c. The identification of the staff or categories of staff who will provide the services d. The schedule and methods of monitoring reviews or assessments of the resident e. The schedule and method of monitoring staff providing services f. A contingency plan that includes the following i. Action to be taken if the scheduled service cannot be provided ii. Information and method for a resident or resident's representative to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition iv. The identification of and information as to who has the authority to sign for the resident in an emergency v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01650			

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01650	Continued From page 27 (21) days	01650			
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	01730			

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01730	Continued From page 28 current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content 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 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: R1 R1 was admitted to the facility on December 31, 2019, and began receiving assisted living services. R1's diagnoses included schizophrenia (a mental disorder where the person hears and sees things that are not real), hypertension, high cholesterol, general anxiety disorder, diabetes type 2 (problems with regulating blood sugar levels), panic attacks, and depression. R1's signed Service Plan (Waiver) - addendum to	01730			

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01730	Continued From page 29 Contract effective date August 9, 2021, indicated R1 received assistance with medication administration. On January 23, 2025, at 11:56 a.m., the surveyor observed unlicensed personnel (ULP)-E administer insulin to R1. R1's medical record, comprised of multiple documents, lacked the following information: - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2 R2 was admitted to the facility on December 31, 2024, and began receiving assisted living services. R2's Service Plan - Waiver effective date January 1, 2025, indicated R2 received assistance with bathing reminder, dressing reminder, grooming reminder, housekeeping, laundry, behavior management, medication reminder, and shopping assistance. R2's medical record, comprised of multiple documents, lacked the following information: - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to	01730			

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01730	Continued From page 30 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. On January 23, 2025, at 10:06 a.m., registered nurse (RN)-E stated the nurse was responsible for completing the medication management plans for each resident. RN-E stated they were unaware of the required content for the medication manage plan. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated the following information would be included, " 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 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	01730			

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01730	Continued From page 31 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 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriber's orders were accurately transcribed 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), 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	01760			

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NAME OF PROVIDER OR SUPPLIER BUTTERFLY BOUND CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3207 67TH 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 32 of the residents). The findings include: R1 was admitted to the facility on December 31, 2019, and began receiving assisted living services. R1's diagnoses included schizophrenia (schizophrenia (a mental disorder where the person hears and sees things that are not real), hypertension, high cholesterol, general anxiety disorder, diabetes type 2 (problems with regulating blood sugar levels), panic attacks, and depression. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received assistance with medication administration. R1's medication administration record (MAR) dated January 1, 2025, through January 21, 2025, indicated R1 received the following medications: aspirin 81 milligram (mg) 1 tablet once daily, Belbuca 150 micrograms (mcg) 1 film three times daily, Bemux 2 mg 1 tablet two times daily, carvedilol 3.125 1 tablet two times daily, Colace 1 capsule once daily, Cymbalta 60 mg 1 capsule once daily, ferrous sulfate 325 mg 1 tablet once daily, fluticasone inhale 2 puffs twice daily, lisinopril 2.5 1 tablet once daily, loratadine 10 mg 1 tablet once daily, Lyrica 150 mg 1 capsule once daily, metformin 1000 mg 1 tablet twice daily, MiraLAX 17 grams (gm) once daily, omega-3 1 capsule twice daily, omeprazole 1 capsule twice daily, pediatric multivitamin-iron chew 2 tablets once daily, psyllium 1 scoop by mouth once daily, senna 2 tablets once daily, spironolactone 50 mg 1 tablet once daily, Vitamin	01760			

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01760	Continued From page 33 B12 1000mg 1 tablet once daily, Align 4 mg 1 tablet once daily, Milk of Magnesia 2 tablespoons once daily, Mounjaro 10 mg 1 inject subcutaneously (under the skin) once per week, Humulin Units-500 inject 550 units twice daily and 600 units at lunch time, Lantus inject 100 units (u) three times daily, estradiol 0.01 % rosuvastatin 40 mg 1 tablet once daily, Caplyta 42 mg 1 tablet once daily, topiramate 250 mg 1 tablet once daily, Zoryve 0.3 % apply to scalp once daily, benzonatate 2 capsule three times daily as needed, magnesium citrate 1 tablespoon once daily as needed, albuterol nebulizer 1 vial every four hours as needed, glucose one tablet as needed for low blood sugar, ibuprofen 400 mg 2 tablets every six hours as needed, ketoconazole shampoo apply as needed, Maalox Plus 15 millimeter (ml) every six hours as needed, Narcan 1 spray in the nostril as needed, oxycodone/acetaminophen 5-325 1 tablet three times daily, Robitussin 10 ml every four hours as needed, simethicone 1 tablet every six hours as needed and, Zofran 4 mg 1 tablet every 12 hours as needed. R1's medical record contained a document titled [R1] signed Medical Doctor orders dated August 5, 2024, and indicated R1 was prescribed the following medications: aspirin 81 milligram (mg) 1 tablet once daily, Bemux 2 mg 1 tablet two times daily, Caplyta 42 mg 1 tablet once daily, carvedilol 3.125 mg 1 tablet two times daily, Colace 1 capsule once daily, Cymbalta 60 mg 1 capsule once daily, ferrous sulfate 325 mg 1 tablet once daily, fluticasone inhale 2 puffs twice daily, Humulin Units-500 inject 550 units twice daily and 600 units at lunch time, Lantus inject 100 units (u) three times daily, lisinopril 2.5 1 tablet once daily, loratadine 10 mg 1 tablet once daily, Lyrica 150 mg 1 capsule once daily,	01760			

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01760	Continued From page 34 metformin 1000 mg 1 tablet twice daily, Milk of Magnesia 2 tablespoons once daily, MiraLAX 17 grams (gm) once daily, Mounjaro 10 mg 1 inject subcutaneously (under the skin) once per week, omega-3 1 capsule twice daily, omeprazole 20 mg 1 capsule twice daily, pediatric multivitamin-iron chew 2 tablets once daily, psyllium 1 scoop by mouth once daily, senna 2 tablets once daily, rosuvastatin 40 mg 1 tablet once daily, spironolactone 50 mg 1 tablet once daily, topiramate 250 mg 1 tablet once daily, Vitamin B12 1000mg 1 tablet once daily, albuterol nebulizer 1 vial every four hours as needed, benzonatate 2 capsule three times daily as needed, magnesium citrate 1 tablespoon once daily as needed, hydrocodone 10-325 mg tablet three times daily. ibuprofen 400 mg 2 tablets every six hours as needed, ketoconazole shampoo apply as needed, Maalox Plus 15 millimeter (ml) every six hours as needed, Narcan 1 spray in the nostril as needed, Oxycodone 5 mg 1 tablet every six hours, Robitussin 10 ml every four hours as needed, Tylenol 325 tablet 1 tablet every hour as needed, and Zofran 4 mg 1 tablet every 12 hours as needed. The following medications were listed on R1's signed orders but were not listed on the MAR: morphine 30 mg 1 tablet twice daily and oxycodone 5 mg 1 tablet every six hours. R1's signed orders indicated hydrocodone 10-325 mg, but on the MAR, it was listed as hydrocodone 5-325. On January 23, 2025, at 3:00 p.m., clinical nurse supervisor (CNS)-C stated the signed medication orders should match R1's MAR. CNS-C stated a copy of any discontinued orders should be available in R1's medical chart.	01760			

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01760	Continued From page 35 The licensee's Medication Orders dated August 1, 2021, indicated licensee would maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain current medication prescriptions 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on December 31, 2019, and began receiving assisted living	01820			

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01820	Continued From page 36 services. R1's diagnoses included schizophrenia (schizophrenia (a mental disorder where the person hears and sees things that are not real), hypertension, high cholesterol, general anxiety disorder, diabetes type 2 (problems with regulating blood sugar levels), panic attacks, and depression. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received assistance with medication administration. R1's medication administration record (MAR) dated January 1, 2025, through January 21, 2025, indicated R1 received the following medications: aspirin 81 milligram (mg) 1 tablet once daily, Belbuca 150 micrograms (mcg) 1 film three times daily, Bemux 2 mg 1 tablet two times daily, carvedilol 3.125 1 tablet two times daily, Colace 1 capsule once daily, Cymbalta 60 mg 1 capsule once daily, ferrous sulfate 325 mg 1 tablet once daily, fluticasone inhale 2 puffs twice daily, lisinopril 2.5 1 tablet once daily, loratadine 10 mg 1 tablet once daily, Lyrica 150 mg 1 capsule once daily, metformin 1000 mg 1 tablet twice daily, MiraLAX 17 grams (gm) once daily, omega-3 1 capsule twice daily, omeprazole 1 capsule twice daily, pediatric multivitamin-iron chew 2 tablets once daily, psyllium 1 scoop by mouth once daily, senna 2 tablets once daily, spironolactone 50 mg 1 tablet once daily, Vitamin B12 1000mg 1 tablet once daily, Align 4 mg 1 tablet once daily, Milk of Magnesia 2 tablespoons once daily, Mounjaro 10 mg 1 inject subcutaneously (under the skin) once per week, Humulin Units-500 inject 550 units twice daily and 600 units at lunch time, Lantus inject 100 units (u)	01820			

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01820	Continued From page 37 three times daily, estradiol 0.01 % rosuvastatin 40 mg 1 tablet once daily, Caplyta 42 mg 1 tablet once daily, topiramate 250 mg 1 tablet once daily, Zoryve 0.3 % apply to scalp once daily, benzonatate 2 capsule three times daily as needed, magnesium citrate 1 tablespoon once daily as needed, albuterol nebulizer 1 vial every four hours as needed, glucose one tablet as needed for low blood sugar, ibuprofen 400 mg 2 tablets every six hours as needed, ketoconazole shampoo apply as needed, Maalox Plus 15 millimeter (ml) every six hours as needed, Narcan 1 spray in the nostril as needed, oxycodone/acetaminophen 5-325 1 tablet three times daily, Robitussin 10 ml every four hours as needed, simethicone 1 tablet every six hours as needed and, Zofran 4 mg 1 tablet every 12 hours as needed. R1's medical record contained a document titled [R1] signed Medical Doctor orders dated August 5, 2024, and indicated R1 was prescribed the following medications: aspirin 81 milligram (mg) 1 tablet once daily, Bemux 2 mg 1 tablet two times daily, Caplyta 42 mg 1 tablet once daily, carvedilol 3.125 mg 1 tablet two times daily, Colace 1 capsule once daily, Cymbalta 60 mg 1 capsule once daily, ferrous sulfate 325 mg 1 tablet once daily, fluticasone inhale 2 puffs twice daily, Humulin Units-500 inject 550 units twice daily and 600 units at lunch time, Lantus inject 100 units (u) three times daily, lisinopril 2.5 1 tablet once daily, loratadine 10 mg 1 tablet once daily, Lyrica 150 mg 1 capsule once daily, metformin 1000 mg 1 tablet twice daily, Milk of Magnesia 2 tablespoons once daily, MiraLAX 17 grams (gm) once daily, Mounjaro 10 mg 1 inject subcutaneously (under the skin) once per week, omega-3 1 capsule twice daily, omeprazole 20 mg 1 capsule twice daily, pediatric	01820			

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01820	Continued From page 38 multivitamin-iron chew 2 tablets once daily, psyllium 1 scoop by mouth once daily, senna 2 tablets once daily, rosuvastatin 40 mg 1 tablet once daily, spironolactone 50 mg 1 tablet once daily, topiramate 250 mg 1 tablet once daily, Vitamin B12 1000mg 1 tablet once daily, albuterol nebulizer 1 vial every four hours as needed, benzonatate 2 capsule three times daily as needed, magnesium citrate 1 tablespoon once daily as needed, hydrocodone 10-325 mg tablet three times daily. ibuprofen 400 mg 2 tablets every six hours as needed, ketoconazole shampoo apply as needed, Maalox Plus 15 millimeter (ml) every six hours as needed, Narcan 1 spray in the nostril as needed, Oxycodone 5 mg 1 tablet every six hours, Robitussin 10 ml every four hours as needed, Tylenol 325 tablet 1 tablet every hour as needed, and Zofran 4 mg 1 tablet every 12 hours as needed. The following medications were listed on the MAR but the licensee did not have a signed order to administer: - Belbuca 150 mcg three times daily. On January 23, 2025, at 10:12 a.m., registered nurse (RN)-E stated the registered nurse was responsible for reviewing each signed order from the medical provider and was responsible for updating the EMAR with any changes. RN-E stated a copy should be available on file. The licensee's Medication Orders policy dated August 1, 2021, indicated the licensee would maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information was provided.	01820			

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01820	Continued From page 39	01820			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
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 permit only authorized personnel to have access to medications 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) 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 January 22, 2025, at 7:22 a.m., during a facility tour, the surveyor observed a split-level home. On the upper level in the dining area was a small white refrigerator that contained the following medications for R1: 27 Mounjaro insulin injection pens, seven Humulin R insulin injections pens, and 19 Lantus solo star injection pens. The refrigerator was not locked and there were no staff present.	01880			

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01880	Continued From page 40 On January 22, 2025, at 7:27 a.m., unlicensed personnel (ULP)-E stated they were trained by the nurse to secure the insulin refrigerator by locking it. The surveyor observed ULP-E remove a key from on top of the nearby water dispenser, lock the refrigerator and place the key into their pocket. ULP-E stated they were trained to keep the keys away from residents. ULP-E stated the nightshift personnel had left the key on top of the water dispenser, and they forgot to take the key from the nightshift personnel. ULP-E stated if the refrigerator is not locked, it's not secured. On January 23, 2025, at 9:58 a.m., registered nurse (RN)-E stated the insulin refrigerator should be locked by staff. RN-E stated medications should not be left unsupervised and that situation should not have happened. The licensee's Storage/Control of Medication policy dated August 1, 2022, indicated licensee would only have authorized personnel to have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as	01960			

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01960	Continued From page 41 ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accurate documentation of residents refusing treatments 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on December 31, 2019, and began receiving assisted living services. R1's diagnoses included schizophrenia (schizophrenia (a mental disorder where the person hears and sees things that are not real), hypertension, high cholesterol, general anxiety disorder, diabetes type 2 (problems with regulating blood sugar levels), panic attacks, and depression. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received assistance with activity assistance, bathing assistance, bedmaking, deep room	01960			

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01960	Continued From page 42 cleaning, grooming, housing keeping, linen exchange, behavior management, meal assistance, medication administration, vital sign recording, garbage removal, and toileting. R1's Treatment and Therapy Plan - dated January 23, 2025, indicated staff were to apply continuous positive airway pressure (CPAP) machine (a machine that uses mild air pressure to keeping the airway open while you sleep), to monitor each night, and to notify the nurse if R1 removed the CPAP machine. R1's Treatment Recap summary dated January 2025 indicated the CPAP machine was administered each day from January 1, 2025, through January 21, 2025, by unlicensed personnel (ULP)-G. On January 21, 2025, at 10:59 a.m., during a facility tour, the surveyor observed the CPAP machine located in R1's room. On January 23, 2025, at 8:30 a.m., R1 stated they had not used their CPAP machine as the electric cord could not be located. On January 23, 2025, 8:30 a.m., agent/licensed practical nurse/licensed assisted living director (A/LPN/LALD)-D stated R1 had been refusing the CPAP machine. On January 23, 2025, at 8:43 a.m., the surveyor asked to A/LPN/LALD-D where the CPAP/BIPap machine was located. A/LPN/LALD-D picked a black bag from R1's closet and opened the bag. The black bag did not contain the CPAP machine. A/LPN/LALD-D left R1's bedroom and returned with a grey bag. The grey bag did not contain the CPAP machine. A/LPN/LALD-D left R1's room	01960			

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01960	Continued From page 43 then returned with a brown box which contained a CPAP machine. There was no electric cord to the machine. On January 23, 2025, at 9:01 a.m., A/LPN/LALD-D stated they were unaware there was no electric cord to the CPAP machine. On January 23, 2025, at 10:18 a.m., registered nurse (RN)-E stated the resident had a right to refuse the CPAP machine. RN-E stated staff were trained to document the treatment as refused not as administered and that situation should not have occurred. The licensee's Treatment and Therapy Management policy dated August 1, 2022, indicated staff should document a treatment as refused and the reason for the refusal from the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced	01970			

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NAME OF PROVIDER OR SUPPLIER BUTTERFLY BOUND CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3207 67TH AVENUE NORTH BROOKLYN CENTER, MN 55429		
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01970	Continued From page 44 by: Based on interview and record review the licensee failed to obtain orders for one of two resident (R1) who received a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on December 31, 2019, and began receiving assisted living services. R1's diagnoses included schizophrenia (schizophrenia (a mental disorder where the person hears and sees things that are not real), hypertension, high cholesterol, general anxiety disorder, diabetes type 2 (problems with regulating blood sugar levels), panic attacks, and depression. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received assistance with activity assistance, bathing assistance, bedmaking, deep room cleaning, grooming, housing keeping, linen exchange, behavior management, meal assistance, medication administration, vital sign recording, garbage removal, and toileting. R1's Treatment and Therapy Plan - dated January 23, 2025, indicated staff were to apply	01970			

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01970	Continued From page 45 continuous positive airway pressure (CPAP) machine (a machine that uses mild air pressure to keeping the airway open while you sleep), to monitor each night, and to notify the nurse if R1 removed the CPAP machine. R1's Treatment Recap summary Dated January 2025 indicated the CPAP machine was administered each day from January 1, 2025, through January 21, 2025, by unlicensed personnel (ULP)-G. R'1 medical record comprised of multiple documents lacked a signed order from a medical provider for the administration of the CPAP machine. On January 23, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-C stated they trained staff to administer the CPAP to R1. CNS-C stated they were aware a copy of the treatment order was required to be kept on file. CNS-C stated they were unable to find a copy of the treatment order. CNS-C stated there was no reason it was not available for review. The licensee's Treatment and Therapy Management policy dated August 1, 2022, indicated the registered nurse (RN) would obtain current prescription orders for all treatment therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02290 SS=F	144G.91 Subd. 2 Legislative intent	02290			

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02290	Continued From page 46 The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee staff imposed a restriction which limited the rights of 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 21, 2025, at 10:59 a.m., during a facility tour, the surveyor observed a notice that stated, "house rules 1. keep the front door locked at all times 2. Visitors to the premises must sign in and out 3. As the client, after the visitor signs in if visitors can be shown to their room 4. No visitors after 9 pm apart from those from the sister facility i.e. [licensee name] or others." On January 23, 2025, at 2:20 p.m., agent/licensed practical nurse/licensed assisted living director (A/LPN/LALD)-D stated that was a policy used during COVID-19 pandemic. A/LPN/LALD-D stated they were aware licensee could not place restrictions on residents having	02290			

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02290	Continued From page 47 visitors. A/LPN/LALD-D stated they were unaware of the house rule posting in the front common area. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) that had hospital-style bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility on December 31,	02310			

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02310	Continued From page 48 2019, and began receiving assisted living services. R1's diagnoses included schizophrenia (a mental disorder where the person hears and sees things that are not real), hypertension, high cholesterol, general anxiety disorder, diabetes type 2 (problems with regulating blood sugar levels), panic attacks, and depression. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received assistance with activity assistance, bathing assistance, bedmaking, deep room cleaning, grooming, housing keeping, linen exchange, behavior management, meal assistance, medication administration, vital sign recording, garbage removal, and toileting. On January 21, 2025, at 10:59 a.m., during a facility tour, the surveyor observed R1's hospital bed with bilateral bed rails. The bed rails had the following identifying information, "REF MDS89697, LOT 88520010004." The entire bed rail measured 32 inches (") and consisted of nine sections. Starting from the left, the first two sections measured 4-and one-half inches wide, with a height of 12". The next five sections measured 3" wide with a height of 18". The last 2 sections measured 4-and one-half inches wide, with a height of 12". The bed rail on the right-hand side was loose and was easily could be pushed back and forth. R1's 90-day assessment dated November 7, 2024, Bed Safety section included the following information: - bed type: standard bed frame hospital bed with 2- and one-half side rails; - mattress type: regular size mattress;	02310			

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02310	Continued From page 49 - side rail in use: partial side rail 2- and one-half for positioning; - bed rails were appropriate based upon assessed needs: yes bed rails to prevent unintentional falls; - resident and/or responsible party have been informed of side rail benefits versus risks: yes, nursing education done on importance of bed rails to prevent falls; - do the bed rails function as a restraint: no; - is the resident at high risk for injury if the bed rails were in use (cognition): low risk; - has the resident had a previous injury related to the bed rails: no; and, - no assisted devices needed for the bed: no comment entered. R1's medical file included an untitled and undated page with a printed picture of a hospital bed with the bed rail zones that were numbered one through seven. The page contained the following printed information, "zone 1 within the rail 2, zone 3 (between the rail and mattress) 3 and one-half inches." Handwritten, next to the picture of the hospital bed by zone number 1 was, "2 inches", and next to the zone 3, "3.5 inches." R1's undated document titled Bed Rail Safety - Plan for [R1], indicated when bed rails were used, an ongoing assessment of R1's mental and physical status was closely monitored and documented. The document included the same untitled and undated page with a printed picture of the hospital bed rail with only two zones measured. Another page titled Actions After a Client Falls indicated eight action items for staff to complete. Another page titled Risk Assessment Benefit Plan contained a flow sheet diagram that instructed staff on what actions to complete related to risk assessment. The last page titled	02310			

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02310	Continued From page 50 Risk Assessment Benefit Plan included a Fall Risk Assessment and a Falls Risk Factor Checklist. R1's record lacked: - bed rail measurements for zones 2 and 4; - the resident's preferences; - physical inspection of the bed rail and mattress for areas of entrapment, stability, and correct installation, and; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On January 22, 2025, at 8:03 a.m., registered nurse (RN)-E stated the RN was responsible for completing bed rail assessments. RN-E stated they were hired to the facility on January 21, 2025, and they were not familiar with the statutes and were not aware of the required information for bed rail use. RN-E stated they believed the resident's strength and mobility should be assessed, and entrapment zones should be measured as part of the assessment. RN-E stated the surveyor was asking questions that RN-E could not answer. On January 22, 2025, at 8:15 a.m., agent/licensed practical nurse/licensed assisted living director (A/LPN/LALD)-D stated the RN was responsible for completing the bed rail assessments and they should be completed every 90 days. A/LPN/LALD-D stated the assessment should include the sections of the bed rail and the height of the bed rail. A/LPN/LALD-D presented the same document titled Bed Rail Safety - Plan for [R1]. The document still lacked the required information as stated above. The surveyor observed A/LPN/LALD-D looking at RTasks (an electronic	02310			

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02310	Continued From page 51 medical record (EMAR)). A/LPN/LALD-D stated the EMAR lacked the documented physical inspection of the bed rail and mattress for entrapment areas, lacked resident preferences, and lacked any necessary information related to interventions to mitigate safety risk to negotiated risk agreements. A/LPN/LALD-D declined to answer when asked if they were aware of the assessment requirements for bed rails. The licensee's Side Rail Use policy dated June 23, 2022, indicated the licensee would include the following information for bed rail assessments: " 1. Before implementing side rails for a resident, the RN will conduct a side rail assessment that includes the following: a. Level of mobility, including bed mobility b. Level of consciousness c. Level of cognition d. Presence of orthostatic hypotension e. Vision 2. The RN will consider the request of the resident, the resident's legal representative and/or the resident's designated representative request for side rails during the evaluation. 3. The RN will discuss with the resident/representative(s) alternatives to the use of side rails. 4. A physical therapy evaluation may be obtained, as appropriate. 5. If the need for side rails is indicated and the resident/resident representative(s) agree to their use, the RN will provide education related to side rails. 6. The RN will document the purpose of the side rails and the education provided. 7. The resident, resident's legal representative or resident's designated representative will co-sign the document agreeing to the benefits and risks of the side rails.	02310			

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02310	Continued From page 52 8. The RN is responsible to ensure that the side rails in use are of a safe design and properly maintained. 9. Side rails will be used consistent with the manufacturer's recommendations. If the manufacturers recommendations are not available, the RN will use appropriate nursing judgment related to the implementation of the side rails. 10. The need for side rails will be re assessed and documented as needed, but not less than every 90 days. 11. Side rails will also be measured upon receiving the bed and measurements will be documented." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, Documentation about a resident's hospital-style bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for	02310			

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02310	Continued From page 53 areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-E) followed appropriate instructions to contact the registered nurse when	02320			

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02320	Continued From page 54 instructed. Additionally, the licensee failed to follow appropriate medication administration processes 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 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: APPROPRIATE TIME TO CONTACT THE REGISTERED NURSE R1 was admitted to the facility on December 31, 2019, and began receiving assisted living services. R1's diagnoses included schizophrenia (schizophrenia (a mental disorder where the person hears and sees things that are not real), hypertension, high cholesterol, general anxiety disorder, diabetes type 2 (problems with regulating blood sugar levels), panic attacks, and depression. R1's signed Service Plan (Waiver) - addendum to Contract effective date August 9, 2021, indicated R1 received assistance with medication administration. R1's medication administration record (MAR) dated January 1, 2025, through January 21, 2025, indicated R1 received the following medications: aspirin 81 milligram (mg) 1 tablet once daily, Belbuca 150 micrograms (mcg) 1 film	02320			

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02320	Continued From page 55 three times daily, Bemux 2 mg 1 tablet two times daily, carvedilol 3.125 1 tablet two times daily, Colace 1 capsule once daily, Cymbalta 60 mg 1 capsule once daily, ferrous sulfate 325 mg 1 tablet once daily, fluticasone inhale 2 puffs twice daily, lisinopril 2.5 1 tablet once daily, loratadine 10 mg 1 tablet once daily, Lyrica 150 mg 1 capsule once daily, metformin 1000 mg 1 tablet twice daily, MiraLAX 17 grams (gm) once daily, omega-3 1 capsule twice daily, omeprazole 1 capsule twice daily, pediatric multivitamin-iron chew 2 tablets once daily, psyllium 1 scoop by mouth once daily, senna 2 tablets once daily, spironolactone 50 mg 1 tablet once daily, Vitamin B12 1000mg 1 tablet once daily, Align 4 mg 1 tablet once daily, Milk of Magnesia 2 tablespoons once daily, Mounjaro 10 mg 1 inject subcutaneously (under the skin) once per week, Humulin Units-500 inject 550 units twice daily and 600 units at lunch time, Lantus inject 100 units (u) three times daily, estradiol 0.01 % rosuvastatin 40 mg 1 tablet once daily, Caplyta 42 mg 1 tablet once daily, topiramate 250 mg 1 tablet once daily, Zoryve 0.3 % apply to scalp once daily, benzonatate 2 capsule three times daily as needed, magnesium citrate 1 tablespoon once daily as needed, albuterol nebulizer 1 vial every four hours as needed, glucose one tablet as needed for low blood sugar, ibuprofen 400 mg 2 tablets every six hours as needed, ketoconazole shampoo apply as needed, Maalox Plus 15 millimeter (ml) every six hours as needed, Narcan 1 spray in the nostril as needed, oxycodone/acetaminophen 5-325 1 tablet three times daily, Robitussin 10 ml every four hours as needed, simethicone 1 tablet every six hours as needed and, Zofran 4 mg 1 tablet every 12 hours as needed. R1's blood glucose (measurement of sugar levels	02320			

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02320	Continued From page 56 in the blood) task instructed staff to notify the registered nurse (RN) if blood glucose was less than 70 or greater than 300. On January 23, 2025, at 11:56 a.m., the surveyor observed ULP-E perform a glucose check on R1 which was 379. ULP-E primed the insulin injection pen to 550 units. Without notifying the registered nurse (RN), ULP-E administered the insulin to R1. On January 23, 2025, at 12:27 p.m., ULP-E stated they were trained to perform the blood glucose on R1 prior to administering the insulin. ULP-E stated they were trained to follow the instruction to contact the RN if the blood glucose was under 70 or over 300. ULP-E stated they did not contact the nurse prior to administering the insulin as the blood glucose number was not, "critical", and would call the RN if the blood glucose was over 500. On January 23, 2025, at 2:07 p.m., clinical nurse supervisor (CNS)-C stated staff were trained to follow the blood glucose instruction and ULP-E should have called the RN. CNS-C stated ULP-E should not have made the decision to administer the insulin to R1. APPROPRIATE MEDICATIONADMINISTRATION PROCEDURES On January 23, 2025, at 11:56 a.m., ULP-E removed a plastic container that contained medication for R1 from in a closet in the hallway. ULP-E walked to the refrigerator locate in the dining area, removed an insulin injection pen and walked to a dining table where R1 was located. ULP-E performed a glucose check on R1 which was 379. Without verifying the correct amount of insulin to administer against the electronic	02320			

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02320	Continued From page 57 medication administration record (EMAR), ULP-E primed the insulin injection pen to administer 550 units of insulin to R1. In the interest of safety, the surveyor intervened on the medication administration. On January 23, 2025, at 12:27 p.m., ULP-E stated they were trained to look at the EMAR and compare the medication before medications were administered. ULP-E stated they forgot to look at the EMAR prior to administrating the medication to R1. On January 23, 2025, at 2:07 p.m., clinical nurser supervisor (CNS)-C stated staff were trained to verify the medications against the EMAR prior to administering medications, including insulin. CNS-C stated staff were probably anxious and that situation should not have occurred. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			



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

Type: Full
Date: 01/22/25
Time: 10:15:00
Report: 1005251016

Food and Beverage Establishment Inspection Report

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Location:

Butterfly Bound Care
3207 67th Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:

ID #: 0037545
Risk:
Announced Inspection: No

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.

4-700 Sanitizing Equipment and Utensils

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

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

THE DISHWASHER WAS NOT ABLE TO PROVIDE A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE. REPAIR OR REPLACE DISHWASHER. SANITIZE DISHES MANUALLY UNTIL REPAIRED, SEE COMMENTS.

Comply By: 01/22/25

4-300 Equipment Numbers and Capacities

4-302.12B **** Priority 2 ****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

THE ONLY PROBE THERMOMETERS ON SITE HAVE A LARGE DIAMETER AND ONLY INDICATE COOKING TEMPERATURES (MINIMUM OF 120 DEGREES F). PROVIDE A SMALL DIAMETER PROBE THERMOMETER TO MEASURE BOTH HOT AND COLD FOODS.

Comply By: 01/29/25

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN

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THE DISHWASHER. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.

Comply By: 01/29/25

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at <160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 35 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR - TOP SHELF
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 33 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR - BOTTOM SHELF
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR - DOOR
Violation Issued: No

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

INSPECTION COMPLETED WITH ALD AND REVIEWED WITH HRD NURSING EVALUATOR KEITH LANGLEY.

INSPECTOR LEFT THERMOLABELS ON SITE AND AFTER INSPECTION OPERATOR STATES THAT THE DISHWASHER DID NOT ACHIEVE A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160 DEGREES F. UNTIL THE DISHWASHER IS ADJUSTED OR REPLACED, MANUALLY SANITIZE DISHES IN 50-100 PPM CHLORINE AFTER WASHING AND RINSING.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

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

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

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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 1005251016 of 01/22/25.

Certified Food Protection Manager SELENA C. BIRABWA

Certification Number: FM112114 Expires: 07/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

DOREEN KALEMA
ALD

Signed: _____

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