Electronically Delivered

October 21, 2024

Licensee
Butterfly Bound Care
3501 62nd Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL35717015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 18, 2024, 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 . . ."

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 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.

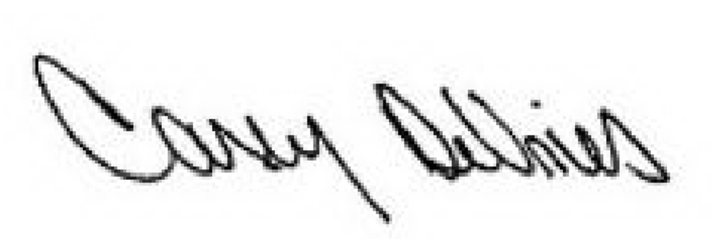
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35717	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	3501 62ND AVENUE NORTH BROOKLYN CENTER, MN 55429

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35717015-0 On September 16, 2024, through September 18, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 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 September 16, 2024, at 2:51 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A provided the surveyor with a copy of the facilities staffing plan. Clinical nurse supervisor (CNS)-B stated that the licensee's staffing plan was developed sometime last November in response to a survey the licensee had in an affiliated facility. CNS-B stated the staffing plan had not been updated since being developed and was unaware this needed to be updated on a bi-annual basis. The licensee's document title Butterfly Bound Care Position Description - Clinical supervisor indicated that the clinical supervisor was responsible for the assuring adequate staffing by preparing and implementing a 24-hour daily staffing plan to meet resident needs at all times, including foreseeable needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 3 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and	0 510		

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0 510	Continued From page 4 control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired on October 13, 2023, to provide assisted living services to residents. On September 17, 2024, from 7:19 a.m. to 7:52 a.m., during continuous observation, the surveyor observed ULP-E complete morning cares for residents residing within the facility. At 7:24 a.m., the surveyor observed ULP-E prepare morning medications for R3. The surveyor observed ULP-E put on clean gloves without completing hand hygiene. The surveyor followed ULP-E into the room of R3 to obtain vital signs and administer morning medications. After completing	0 510		

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0 510	Continued From page 5 medication administration and collection of vital signs, the surveyor observed ULP-E remove their soiled gloves at 7:34 a.m., ULP-E did not perform hand hygiene. On September 17, 2024, at 7:39 a.m., ULP-E stated that they were trained on infection control practices at the time of hire and annually afterwards by the registered nurse. The surveyor then observed ULP-E again put on clean gloves without completing hand hygiene to prepare scrambled eggs for residents. After cracking eggs into a mixing bowl, the surveyor observed ULP-E go to the kitchen sink and rinse their gloves off in the sink. At 7:43 a.m., the surveyor observed ULP-E give a verbal report to the oncoming staff and remove the cooked eggs from the stove. At 7:44 a.m., the surveyor again observed ULP-E rinse the same gloves in the sink. At 7:45 a.m., while wearing the same gloves, the surveyor observed ULP-E deliver the cooked eggs to the room of R3. After delivering the eggs, the surveyor observed ULP-E cleaning around the sink and cooking area while wearing the same gloves. At 7:46 a.m., the surveyor observed ULP-E wash the same gloves in the sink. After completing washing gloves at the sink, the surveyor observed ULP-E remove the soiled gloves, and complete hand hygiene at the sink. At 7:48 a.m., the surveyor observed ULP-E use the paper towel that was used for the drying of hands to wipe off the area surrounding the sink. On September 17, 2023, at 8:07 a.m., clinical nurse supervisor (CNS)-B stated that staff are trained and expected to complete hand hygiene before and after putting on clean gloves. Additionally, gloves should be changed between cares, and gloves should never be washed off in the sink.	0 510		

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0 510	Continued From page 6 The licensee's Infection Control policy dated August 1, 2021, indicated that Butterfly Bound Care will observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.1-2 read: 1.) Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 7 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). 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: On September 16, 2024, at 1:17 p.m., the licensee provided a copy of their facility Tuberculosis (TB) Risk Assessment, which was	0 660		

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0 660	Continued From page 8 dated November 22, 2021. The assessment form indicated the facility was a at a low risk. On September 17, 2024, at 1:47 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated they were aware that the facility's TB risk assessment needed to be completed on an annual basis, but that it had slipped their mind. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the director is responsible for conducting the formal TB Risk Assessment and updating it annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 9 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 17, 2024, at 12:18 p.m., the surveyor reviewed the licensee's emergency preparedness plan. Licensed assisted living director/licensed practical nurses (LALD/LPN)-A retrieved the facility's fire safety plan from a neighboring affiliated facility. The licensee's fire safety plan was not stored on site. The licensee's written emergency disaster	0 680		

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0 680	Continued From page 10 preparedness plan lacked evidence of the following required content: - Annual review of the Emergency Preparedness Plan; - Quarterly review of missing resident policy; - A written risk assessment utilizing an all-hazards approach; - Categorization of probable risks by likelihood of occurrence; - Written strategies addressing facility and community-based risks; - Annual review and/or updates of policies; - Policies and procedures for subsistence needs for staff and residents; - Policies and procedures to address needs for staff and residents whether evacuated or sheltered in place; - Policies and procedures for the safe/sanitary storage of provisions; - Policies and procedures for volunteers; - Arrangements with other facilities; - Development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - Roles under wavier declared by secretary; - Policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver; and, - Annual review of the Communication Plan. On September 17, 2024, at 12:44 p.m., clinical nurse supervisor (CNS)-B, and LALD/LPN-A stated the licensee reviews their missing person policy on an annual basis. On September 17, 2024, at 1:00 p.m., house manager (HM)-C stated they were responsible for the development of the facility's EPP, and they had forgotten to update the licensee's EPP as	0 680		

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0 680	Continued From page 11 they were focused on updating EPPs for other affiliated facilities. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the following: "Butterfly Bound Care will have an identified plan in place to assure the safety and 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		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing	0 780		

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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
0 780	Continued From page 12 smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. 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 September 17, 2024, at 10:45 a.m. to 11:50 a.m., surveyor toured the facility with licensed assisted living director/licensed practical nurse (LALD/LPN)-A. Surveyor tested the smoke alarms throughout the home. Upon testing, the smoke alarms in the basement were not interconnected with the smoke alarms on the main floor. These deficient conditions were visually verified by LALD/LPN-A accompanying on the tour and he stated that he understood the smoke alarm requirements.	0 780		

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0 780	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level 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:	0 800		

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0 800	Continued From page 14 On September 17, 2024, at 10:45 a.m. to 11:50 a.m., surveyor toured the facility with licensed assisted living director/licensed practical nurse (LALD)-A. The following was observed: GENERAL MAINTENANCE: Broken window in the dining room. Hole in the door that goes down to the basement. Bedroom #1 door off the kitchen had wood fallen off and missing its finishes. Clothes and personal items were blocking the doors and could block the resident way of egress. Bedroom #2 door finishes were peeling off. Paint on the wall by the bed was chipping off. Bedroom #3 closet door had a hole in it and door finishes coming off. Vent was full of black dust. Main floor bathroom vent and shower curtain holder had rust due to lack of ventilation. Ceiling had several water stains. On September 17, 2024, at 11:50 a.m., LALD/LPN-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810		

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0 810	Continued From page 15 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 16 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 September 17, 2024, at 11:45 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A provided documents on the fire safety and evacuation training, and evacuation drills for the facility. LALD/LPN-A was unable to provide any Fire Safety and evacuation plan. LALD/LPN-A had gone to another location to see if it was there and was unable to locate it. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to	0 820		

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0 820	Continued From page 17 correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility tour with the licensed assisted living director/licensed practical nurse (LALD/LPN)-A on September 17, 2024, between 10:45 a.m. and 11:50 a.m. it was observed that cigarette butts were found on the garage floor and back patio cement and yard. The surveyor explained to the LALD/LPN-A, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place outside in the designated area away from the structure. The deficient condition was visually verified by the LALD/LPN-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		

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01290	Continued From page 18	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for four of seven employees (house manager (HM)-C, unlicensed personnel (ULP)-E, 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) 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:	01290		

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01290	Continued From page 19 HM-C HM-C was hired on October 25, 2020, and began providing assisted living services on August 1, 2021. HM-C's employee record contained a background study clearance dated December 27, 2022, affiliated to licensee's sister facility HFID# 32914. HM-C's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey. ULP-E ULP-E was hired on October 13, 2023, to provide assisted living services. ULP-E's employee record contained a background study clearance dated October 11, 2023, affiliated to licensee's sister facility HFID# 32914. ULP-E's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey. The licensee's employee schedule indicated ULP-E worked independently and unsupervised from 7:30 p.m., to 7:30 a.m., on September 14, September 15, September 16, September 17, and September 17, 2024. ULP-F ULP-F was hired on May 12, 2025, to provide assisted living services. ULP-F's employee record contained a background study clearance dated May 22, 2024, affiliated to licensee's sister facility HFID# 37324. ULP-F's record lacked evidence the licensee	01290		

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01290	Continued From page 20 submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey. The licensee's employee schedule indicated ULP-Fworked independently and unsupervised from 7:30 a.m. to 7:30 p.m., on August 31, 2024, and September 7, 2024. ULP-G ULP-G was hired on April 28, 2024, to provide assisted living services. ULP-G's employee record contained a background study clearance dated March 6, 2024, affiliated to licensee's sister facility HFID# 35716. ULP-F's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey. The licensee's employee schedule indicated ULP-G worked independently and unsupervised from 7:30 a.m. to 7:30 p.m., on September 14, 2024, and was scheduled to work unsupervised on September 21, 2024. On September 18, 2024, at 11:17 a.m., HM-C stated they were responsible for running and maintaining the license's background studies. HM-C stated they were unaware they needed to run a background study for every site that staff worked. The undated Licensee's Background Studies policy dated August 1, 2021, indicated that the facility requires background screening to be completed on all employees, contractors, and regularly scheduled volunteers. Employees will	01290		

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01290	Continued From page 21 not be able to start working with residents until the background check clearance has been received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures	01500		

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01500	Continued From page 22 relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of one employee (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	01500		

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01500	Continued From page 23 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: CNS-B started employment with licensee April 14, 2022, to provide assisted living services, clinical oversight, orientation, training and competency testing, and supervision of unlicensed personnel. CNS-B's employee record lacked at least eight hours of annual training for each 12 months of employment in the following topics: - Reporting maltreatment of vulnerable adults or minors; - Assisted Living bill of rights; - Infection control techniques; - Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - Review of provider's policies and procedures; - Principles of person-centered planning/service delivery; - Hearing loss training (optional); and, - Dementia Training: Met two (2) hours annually. On September 17, 2024, at 2:12 p.m., CNS-B stated they had not completed annual training at this licensee, but they had completed annual training at a hospital that they work at. CNS-B stated they were under the assumption that this annual training would cover required components. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated that All	01500		

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01500	Continued From page 24 staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment. Education topics will include, but not be limited to, the following: - Reporting of maltreatment of adults; - Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Review of the organization's policies and procedures related to provision of assisted living services and how to implement them; - Infection control techniques used in the home; - Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease, or related disorders; and, - The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	01890		

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01890	Continued From page 25 Based on observation, interview, and record review, the licensee failed to ensure medications were kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug as well as disposing of expired medications. This had a potential to affect all 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 the residents). The findings include: On September 17, 2024, at 11:22 a.m., during an audit of the licensee's medication storage, the surveyor observed the following expired medications: - Hydroxyzine hcl 10mg tablets belonging to R2, with an expiration date of September 29, 2023. - Hydroxyzine 10 mg tablets belonging to R2, with an expiration date of July 26, 2024. On September 17, 2024, at 11:22 a.m., during an audit of the licensee's medication storage, the surveyor observed the following medications stored outside of their original container. - Multiple unidentified medications in the storage bins belonging to R2 and R3. - In the storage bins belonging to R2 and R3, the surveyor discovered resident medications taped to a page of paper with resident names,	01890		

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BUTTERFLY BOUND CARE	3501 62ND AVENUE NORTH BROOKLYN CENTER, MN 55429

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01890	Continued From page 26 medication names, and dosage information on the medications being provided to residents. On September 17, 2024, at 11:44 a.m., clinical nurse supervisor (CNS)-B stated that medications that were found loose in the medication bin were to be disposed of by staff according to facility policy. CNS-B stated they were responsible for the disposal of expired medications, and expired medications not being disposed of was a failure on their part. On September 17, 2024, at 12:11 p.m., CNS-B stated the sheets of paper found the resident medication bins with medications taped to them were created with the intention of creating a tool for staff to use when administering medications to help staff identify medications and prevent medication errors. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated that prescription drugs, prior to being set up for immediate or later administration, must be kept in the original container(s) in which they were dispensed by the pharmacy bearing the original prescription label with legible information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35717	A. BUILDING: _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	3501 62ND AVENUE NORTH BROOKLYN CENTER, MN 55429

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02320	Continued From page 27 and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (unlicensed personnel (ULP)-E) followed appropriate medication administration procedures. 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 September 17, 2024, at approximately 7:23 a.m., the surveyor observed ULP-E administer Jardiance 10 milligrams (mg), Spironolactone 50mg, Amlodipine 5mg, Entresto 97-103mg and Carvedilol 12.5mg to R3. The surveyor observed ULP-E take the medication from the medication closet, open the pharmacy prefilled bubble pack that was labeled with the correct date and time and administer the medication to R3. ULP-E did not utilize the medication administration record (MAR) during the medication administration process which included documentation of the medication administration. On September 17, 2024, at 7:34 a.m., ULP-E stated they do not document medications that are	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 28 given at this time in the morning, as they are a part of the morning shift's scheduled medications. ULP-E stated they were a night shift staff and these medications were on the morning shifts scheduled tasks. ULP-E stated they would administer the medications, and then inform the oncoming staff the medications were administered. The morning staff would then complete the documentation. The surveyor asked ULP-E if they had checked the medications against the MAR to ensure that the correct medications were being administered. ULP-E did not answer the question and again stated they would tell the oncoming shift that the medications were administered. On September 17, 2024, at 7:55 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated staff are trained to check medications against the MAR prior to administration and that staff who administer medications are required to document medications as having been administered. LALD/LPN-A then directed ULP-E to complete the documentation of medication administration. On September 17, 2024, at 8:07 a.m., clinical nurse supervisor (CNS)-B stated staff are trained to verify medications using the five rights of medication administration, and staff who administered the medications should be the staff who document on the medications. On September 17, 2024, at 8:57 a.m., the surveyor observed CNS-B complete administration of 0.25mg of Ozempic for R2. The surveyor did not observe CNS-B verify this medication against the MAR, or document the medication in the MAR. When asked if CNS-B had checked the medication against the MAR,	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35717	A. BUILDING: _____ B. WING _____	09/18/2024

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02320	Continued From page 29 CNS-B opened a laptop, logged into R-tasks (electronic record software), and then opened R2's medication list to use as a verification tool. When asked why CNS-B did not utilize the MAR for verification and documentation prior to the administration, CNS-B stated they did not have access to the MAR, as medication administration was a delegated task, and only ULP had access to that portion of the chart. The surveyor asked how the CNS documented the administration of the Ozempic, CNS-B stated the resident received the medication once a week, so they documented in the resident's weekly nursing note. On September 17, 2024, at 9:30 a.m., the surveyor observed house manager (HM)-C give instruction to CNS-B on how to access resident MARs. On September 17, at 9:33 a.m., CNS-B stated they did not realize they had access to the MAR up until today. The licensee's medication documentation policy dated August 1, 2021, indicated each medication administered by Butterfly Bound Care staff will be documented in the resident's clinical record. Documentation will be complete, accurate, and legible. 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
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *09/16/24*
Time: 15:42:56
Report: 8058241241

Food and Beverage Establishment Inspection Report

Location:
Butterfly Bound Care
3501 62nd Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0039213
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.

3-500B Microbial Control: hot and cold holding

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

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

COOLER TEMPERATURE ADJUSTED DURING INSPECTION

Comply By: 09/16/24

4-300 Equipment Numbers and Capacities

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

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

SEE COMMENTS

Comply By: 12/18/24

Food and Equipment Temperatures

Process/Item: BUTER
Temperature: 44 Degrees Fahrenheit - Location: COOLER
Violation Issued: Yes

Process/Item: TOMATO
Temperature: 45 Degrees Fahrenheit - Location: COOLER
Violation Issued: Yes

Type: Full
Date: *09/16/24*
Time: 15:42:56
Report: 8058241241
Butterfly Bound Care

Food and Beverage Establishment Inspection Report

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

HRD INSPECTOR: ZACH MORTH

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

- ESTABLISHMENT HAS ONLY A TWO COMPARTMENT SINK AND DOES NOT HAVE A DISH WASHER.

EITHER A 3 COMPARTMENT SINK OR A DISH WASHER CAPABLE OF SANITIZING DISHES MUST BE INSTALLED.

A BIN IS BEING USED TEMPORARILY AS A THIRD SINK COMPARTMENT

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 8058241241 of 09/16/24.

Certified Food Protection Manager: SELINA BIRABWA

Certification Number: 112114 Expires: 07/27/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
DOREEN KALEMA
ASST. LIVING DIRECTOR

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us