DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 12, 2022

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

RE: Project Number(s) SL35716015

Dear Administrator:

On September 7, 2022, the Minnesota Department of Health completed a follow-up evaluation of your faccility to determine if orders from the June 22, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

July 22, 2022

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

RE: Project Number(s) SL35716015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 22, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general Free from Maltreatment reconsideration

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

requests should be addressed to:
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Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35716	A. BUILDING: _____ B. WING _____	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	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 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: SL35716015 On June 21, 2022, through June 22, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all three residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the additional documentation included in the "Food and Beverage	0 480	Minnesota Department of Health is documenting the State Licensing 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	

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0 480	Continued From page 2 Establishment Inspection Reports," dated June 21, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480	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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical	0 510		

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0 510	Continued From page 3	0 510		

and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff and visitors entering or re-entering the building were screened for COVID-19 with documented temperatures and symptom screening questions. The licensee failed to ensure staff wore masks and eye protection while working with residents. This had the potential to affect all 3 residents, staff, and visitors at the licensee.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On June 21, 2022, at approximately 9:30 a.m., when the surveyors arrived at the licensee's facility they were screened for COVID-19 signs and symptoms and temperatures taken. Registered nurse (RN)-A and the residents present in the living area did not have their masks on.

On June 21, 2022, at approximately 10:00 a.m., during the entrance conference, RN-A, licensed assisted living director (LALD)-C and house manager/unlicensed personnel (ULP)-D did not have their masks or eye protection on.

On June 21, 2022, at approximately 11:30 a.m., RN-A stated the licensee was following the state no mask mandate order but was not aware of Centers for Disease Controls (CDC) and

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0 510	Continued From page 4 Minnesota Department of Health (MDH) guidelines. On June 22, 2022, at approximately 7:20 a.m., the surveyor arrived at the licensee and screened self but thermometer was not available to take temperature. ULP-B and ULP-E did not have their masks and eye protection on. The MDH COVID-19 PPE and Source Control Grids For Congregate Care Settings, by Community Transmission Level dated April 7, 2022, indicated staff should wear source control PPE when they are in areas of the health care facility where they could encounter residents. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee will follow the MDH guidelines for COVID-19 protocols. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	0 630		

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0 630	Continued From page 5 self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to licensee on December 31, 2019, under the comprehensive license and started receiving assisted living services on August 1, 2021. R1's diagnoses included diabetes, depression, panic attacks and generalized anxiety. R1's IAPP dated May 17, 2022, included vulnerabilities to include risk to be abused by others, impaired judgment, difficulty using the phone, verbally aggressive, destructive behavior, anxious, and disoriented. R1's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.	0 630		

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0 630	Continued From page 6 On June 21, 2022, at approximately 3:10 p.m., registered nurse (RN)-A acknowledged the IAPP was missing statements of the specific measures to be taken to minimize the risk of abuse. The licensee's Vulnerable Adult policy dated August 1, 2021, indicated licensee will develop specific plan to minimize the risk of abuse to that resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	0 650		

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0 650	Continued From page 7 (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of one employee unlicensed personnel (ULP-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client'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: ULP-B started employment on October 25, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B record lacked annual training to include - Reporting maltreatment of vulnerable adults or minors - Review of provider's policies and procedures - Principles of person-centered planning/service	0 650		

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0 650	Continued From page 8 delivery ULP-B's record also lacked annual performance reviews completed by the licensee. On June 22, 2022, at approximately 10:35 a.m., the licensed assisted living director (LALD)-C acknowledged ULP-B record was missing the content above, and stated all the training was completed except the licensee misplaced the records. Also stated if licensee will not find the missing record ULP-B will be retrained. The licensee's Employee Record policy dated August 1, 2021, indicated licensee will maintain record of all employees providing services to include the content above. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 9 and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan 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 June 22, 2022, at approximately 11:30 a.m., the licensee's Emergency Preparedness (EP) plan was reviewed. The licensee's plan lacked the following required content:	0 680		

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0 680	Continued From page 10 - EP Program Patient Population - Process for EP Collaboration - Subsistence Needs for Staff and Patients - Procedures for Tracking of Staff and Patients - Policies and Procedures Including Evacuation - Policies and Procedures for Sheltering - Policies and Procedures for Medical Documents -Policies and Procedures for Volunteers - Roles under a Waiver Declared by Secretary - Development of Communication Plan - Primary/Alternate Means for Communication - Methods for Sharing Information - Sharing Information on Occupancy/Needs - LTC Family Notifications On June 22, 2022, at approximately 12:10 p.m., licensed assisted living director (LALD)-C acknowledged the EP plan was not complete and stated the licensee will update their EP plan to reflect the requirements. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee will have a plan in place to asssure safety and wellbeing of residents and staff during periods of emergency. The policy lacked all the content identified missing above. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 800		

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BUTTERFLY BOUND CARE	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
0 800	Continued From page 11 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On June 21, 2022, from approximately 11:30 a.m. to 12:15 p.m., survey staff toured the facility with the unlicensed professional (ULP)-D. During the facility tour, survey staff observed water damage on the ceiling of the basement bathroom. The ceiling was dry at the time of the survey, but the surfaces and finishes had not been repaired. The licensee did not have a maintenance schedule for the ceiling work. The survey staff also found evidence of water damage to the upstairs bathroom floor immediately outside the shower. The vinyl floor material was damaged and peeling up from the old tile floor below. The licensee did not have a maintenance schedule for the floor work.	0 800		

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0 800	Continued From page 12 ULP-D verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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	0 810		

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0 810	Continued From page 13 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 interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During interview on June 21, 2022, at 12:15 p.m., the unlicensed professional (ULP)-D stated the facility did training for staff and residents twice a year. She was not certain how often they were doing evacuation drills. Review of the fire policy showed the licensee had conducted an evacuation drill on March 14, 2022, and November 05, 2021. Evacuation drill frequency is not compliant with the statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 14 (21) days	0 810		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 950		

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0 950	Continued From page 15 contract included the designation of representative statutory language for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to license on December 31, 2019, under the comprehensive license, and started receiving assisted living services on August 1, 2021. R1's Resident Contract for Assisted Living signed and dated March 23, 2022, lacked the verbatim "right to designate a representative for certain purposes" notice required at the time of execution of the contract. On June 21, 2022, at approximately 11:10 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C acknowledged the required verbatim notice was not included in the resident's contract. They also stated the same contract was used for all the licensee's residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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0 970	Continued From page 16	0 970		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client 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 of the residents). The findings include: R1 was admitted to license on December 31, 2019, under the comprehensive license, and started receiving assisted living services on August 1, 2021. R1's Assisted Living Contract signed and dated March 23, 2021, indicated the licensee was not liable for any damage or injury to the resident or	0 970		

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0 970	Continued From page 17 any other person or to any property occuring on the licensee's premises. On June 21, 2022, at approximately 12:00 p.m., registered nurse (RN)-A and licensed assisted living director (LALD)-C acknowledged the contract waived the licensee's liability for the health, safety, or personal property of a resident. They also stated the same contract was used for all the licensee's residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
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	01290		

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01290	Continued From page 18 background study was affiliated to the current license for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-B started employment on October 25, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 22, 2022, at approximately 7:45 a.m., ULP-B administered medications to R1. ULP-B's background application was completed in September 21, 2020, but did not have a clearance on file. On June 22, 2022, at approximately 12:35 p.m., licensed assisted living director (LALD)-C attempted to verify ULP-B's background clearance on the Department of Health and Human Services (DHS) website, but was not able to get any results back. On June 22, 2022, at approximately 12:50 p.m., DHS Netstudy 2.0 website stated ULP-B was affiliated to licensee on September 21, 2020, under the comprehensive license.	01290		

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01290	Continued From page 19 On June 22, 2022, at approximately 1:00 p.m., LALD-C acknowledged ULP-B's record lacked a background study for the current assisted living license. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated licensee will appropriately screen prior to employment, also indicated criminal background will be submitted to the Department of Human Services. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	01470		

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01470	Continued From page 20 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 the challenges it poses to communication; (2) 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 observation, interview and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-B)	01470		

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01470	Continued From page 21 received orientation to assisted living facility licensing requirements and regulations with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-B started employment on October 25, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 22, 2022, at approximately 7:45 a.m., ULP-B administered medications to R1. ULP-B's record lacked evidence of completed orientation prior to providing assisted living services to include: - Overview of Assisted Living statutes - Review of provider's policies and procedures - Review of types of Assisted Living services the employee will provide - Principles of person-centered planning/service delivery On June 22, 2022, at approximately 11:50 a.m., licensed assisted living director (LALD)-C acknowledged ULP-B's record was missing required orientation and stated the employee will complete the orientation.	01470		

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01470	Continued From page 22 The licensee's Staff Orientation and Education policy dated August 1, 2021, indicated all staff will be prepared to provide safe, effective services through a thorough orientation and education program to include all the missing content above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.	01620		

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01620	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 licensee on December 31, 2019, under the comprehensive license and started receiving assisted living services on August 1, 2021. R1's diagnoses included diabetes, depression, panic attacks and generalized anxiety. R1's record included 90-day assessments completed on October 28, 2021, February 15, 2022, and May 17, 2022, respectively. The assessments exceeded the 90-day calendar days by 20 days and one day, respectively. On June 22, 2022, at approximately 1:20 p.m., licensed assisted living director (LALD)-C acknowledged resident monitoring and reassessment exceeded 90 calendar days, and stated the RN will put in place reminders when	01620		

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01620	Continued From page 24 the assessments are due. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the RN will conduct comprehensive assessments for all residents but lacked verbiage to include 90-day requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=C	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; (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	01650		

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BUTTERFLY BOUND CARE	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
01650	Continued From page 25 (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 ensure the service plan included the required content for one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to licensee on December 31, 2019, under the comprehensive license and started receiving assisted living services on August 1, 2021. R1's service plan dated August 10, 2021, indicated R1 was receiving services to include: activity assistance, bathing, bedmaking, deep room cleaning, dressing, grooming, housekeeping, linen change, behavior management, meal assistance, medication administration, blood glucose monitoring, vital signs, and shpoping assistance. R1's service plan lacked the the fees for services.	01650		

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01650	Continued From page 26 On June 21, 2022, at approximately 12:30 p.m., licensed assisted living director (LALD)-C acknowledged R1's service plan was missing required content and stated the same service plan was used by the licensees' residents. The licensee's Service Plan policy dated August 1, 2021, indicated service plan is implemented for all residents, and licensee will provide all services required by current service plan. In addition, the policy indicated the missing content will be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling	01690		

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01690	Continued From page 27 and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the security and accountability of a controlled substance was maintained for one of one resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2's diagnoses included major depressive disorder with psychotic suicidal features, auditory and visual hallucinations, and borderline personality disorder.	01690		

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01690	Continued From page 28 R2's service plan dated August 11, 2021, indicated R2 was receiving services to include activity assistance, bathing, bedmaking, medication administration, and vital signs. R2's signed provider orders dated August 30, 2021, indicated R2 was receiving medications to include: - Abilify 400 milligram (mg) inject once a month - benztropine 0.5 mg tablet twice a day - colace 100 mg tablet two times daily - Effexor 150 mg tablet daily - lithium carbonate 450 mg tablet give three tablets at bedtime daily - Zofran 4 mg tablet under tongue as needed On June 22, 2022, at approximately 7:50 a.m., unlicensed personnel (ULP)-B administered medications to R2. On June 22, 2022, at approximately 10:00 a.m., the surveyor completed a review of R2's medication storage area, and observed a medication bottle labeled lorazapam 0.5 mg tablet give one tablet daily as needed, containing eleven tablets. Inside the bottle, there was one different pill white in color, slightly larger in size than the rest, and was imprinted 54733 which was identified as morphine 15 mg tablet. R2's Medication Count log for lorazapam dated June 21, 2022, indicated there were nine tablets remaining in the storage bottle, but a physical count confirmed there were eleven tablets remaining including the morphine 15 mg tablet. On June 22, 2022, at approximately 12:15 p.m., licensed assisted living director (LALD)-C acknowledged the findings and stated the licensee could neither explain the counting	01690		

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01690	Continued From page 29 discrepancy nor how morphine ended up in lorazapam bottle. LALD-C also stated registered nurse (RN)-A will investigate and retrain the unlicensed personnel. The licensee's Storage/Control of Medication policy dated August 1, 2021, indicated all medications are securely locked in substantially constructed compartments according to manufacturer's direction. The policy also indicated the RN will provide for security, accountability and overall management of controlled substances. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	01730		

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01730	Continued From page 30	01730		

relating to the administration of medications;
(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;
(5) identification of medication management tasks that may be delegated to unlicensed personnel;
(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1) with record reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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

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01730	Continued From page 31 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 22, 2022, at approximately 7:30 a.m., unlicensed personnel (ULP)-B administered medications to R1. R1's signed provider orders dated August 16, 2021, indicated R1 was receiving medications to include: - aspirin 81 milligram (mg) daily - Bumex 2 mg two times daily - carvedilol 3.125 mg tablet two times daily - colace one capsule two times daily - Detrol LA 4 mg tablet daily - Humulin R U-500 subcutaneous three times per day - Lantus 100 unit/milliliter subcutaneous per day - lisinopril 2.5 mg tablet daily R1's assessment (individual medication management plan) dated May 17, 2022, lacked the content to include: - Medication management services provided by the registered nurse (RN) and ULPs - Specific written instructions for resident medication administration - Procedures for staff to notify an RN when problems arose. On June 22, 2022, at approximately 9:20 a.m., licensed assisted living director (LALD)-C acknowledged R1's individualized medication management plan was missing content, and stated licensee will update it to reflect the requirement. The licensee's Service Plan for Medication	01730		

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01730	Continued From page 32 Management policy dated August 1, 2021, indicated teh licensee will prepare and document a medication management plan for each resident. In addition, all the missing content will be included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		
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, interview and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider managed for one of one resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01820		

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01820	Continued From page 33 R2's diagnoses included major depressive disorder with psychotic suicidal features, auditory and visual hallucinations, and borderline personality. R2's service plan dated August 11, 2021, indicated R2 was receiving services to include activity assistance, bathing, bedmaking, medication administration, and vital signs. On June 22, 2022, at approximately 7:50 a.m., unlicensed personnel (ULP)-B administered medications to R2. R2's signed provider orders dated August 30, 2021, indicated R2 was receiving medications to include: - Abilify 400 milligram (mg) inject once a month - benztropine 0.5 mg tablet twice a day - colace 100 mg tablet two times daily - Effexor 150 mg tablet daily - lithium carbonate 450 mg tablet give three tablets at bedtime daily - Zofran 4 mg tablet under tongue as needed R2's unsigned discharge summary dated June 17, 2022, indicated R2 was receiving lorazapam 0.5 mg tablet daily as needed for anxiety, and trazodone HCL 50 mg tablet at bedtime. R2's record lacked current written or electronically recorded prescriptions for lorazepam and trazodone. On June 22, 2022, at approximately 1:20 p.m., licensed assisted living director (LALD)-C acknowledged R2 was missing current written or electronically recorded prescription for some medications, and stated the registered nurse will update records.	01820		

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01820	Continued From page 34 The licensee's Storage/Control of Medication policy dated August 1, 2021, indicated all prescription drugs are securely locked in substantially constructed compartments according to manufacturer's direction. The policy lacked verbiage to include obtaining current written or electronically recorded prescription. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were not expired for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01890		

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01890	Continued From page 35 situation has occurred only occasionally). The findings include: R1's service plan dated August 10, 2021, indicated R1 was receiving services to include: activity assistance, bathing, bedmaking, medication administration, blood glucose monitoring, oxygen, and vital signs. R1's signed provider orders dated August 16, 2021, indicated R1 was receiving medications and treatments to include: - aspirin 81 milligram (mg) daily - Bumex 2 mg two times daily - carvedilol 3.125 mg tablet two times daily - colace one capsule two times daily - Detrol LA 4 mg tablet daily - Humulin R U-500 subcutaneous three times per day - Lantus 100 unit/milliliter subcutaneous per day - lisinopril 2.5 mg tablet daily - oxygen two liter per nasal cannula continuously, if less than 92% notify registered nurse - blood glucose monitoring four times per day On June 22, 2022, at approximately 7:30 a.m., unlicensed personnel (ULP)-B administered medications to R1. On June 22, 2022, at 8:36 a.m., the surveyor reviewed the medication storage area. The surveyor observed the following expired medications and confirmed with licensed assisted living director (LALD)-C: two Novolog Flexpens expired on April 28, 2021, and Narcan nasal spray 4 mg as needed expired in September 2021. On June 22, 2022, at approximately 9:40 a.m.,	01890		

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01890	Continued From page 36 LALD-C acknowledged the expired medications and stated the registered nurse checks the medication storage area monthly to ensure no expired medications. The licensee's Disposition and Disposal of Medication policy dated August 1, 2021, indicated the licensee will dispose of expired medications according to policy. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the required content for one of one discharged resident (R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R3 discharged from the licensee on February 22, 2022. R3's service plan dated August 12, 2021, indicated R3 was receiving services to include: grooming, housekeeping, behavior management and medication management. R3's signed provider orders dated August 23, 2022, indicated R3 medications included: - gabapentin 300 milligram (mg) tablet three times daily - Latuda 40 mg tablet daily in the evening - omeprazole 20 mg capsule two capsules two times daily - trazodone 100 mg tablet at bedtime daily - Toviaz 8 mg tablet daily - verapamil 240 mg tablet daily - Zyrtec 10 mg tablet daily	01910		

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01910	Continued From page 38 - meclizine 25 mg tablet three times a day as needed R3's record lacked a medication disposition record to include: quantity, date of disposition, and names of staff and other individuals involved in the disposition. On June 21, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-C acknowledged the medication disposition record was missing required content as noted above. The licensee's Disposition and Disposal of Medication policy dated August 1, 2021, indicated the licensee will dispose of expired medications according to policy, and include all the missing content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 39 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included schizophrenia, type II	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35716	A. BUILDING: _____ B. WING _____	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	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
01940	Continued From page 40 diabetes, hypertension and panic attacks. R1's service plan dated August 10, 2021, indicated R1 was receiving services to include: activity assistance, bathing, bedmaking, medication administration, blood glucose monitoring, oxygen, and vital signs. R1's prescriber's signed orders dated August 13, 2021, indicated R1 was receiving blood sugar monitoring four times per day and oxygen two liters per nasal cannula continuously (monitor and record oxygen saturation, if less than 92% notify registered nurse (RN)). R1's individualized treatment and therapy management plan lacked the content to include: - Written instructions for each treatment or therapy - A list of the treatment or therapy tasks delegated to unlicensed personnel (ULP) - Procedures to notify an RN or other licensed health professional when problems arose with treatments or therapies - Resident-specific instructions related to documentation of all treatments and/or therapies administered, or reason not administered, verified as administered and monitored to prevent complications or adverse reactions. On June 22, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-C acknowledged R1's individualized treatment and therapy management plan lacked the required content. In addition, LALD-C stated the licensee will update the plan to reflect the requirement. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the individualized treatment and therapy	01940		

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01940	Continued From page 41 management plan will have all the missing content. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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 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 treatments were transcribed as prescribed for one of one resident (R1) with record reviewed for 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).	01960		

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	35716	A. BUILDING: _____ B. WING _____	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	3207 67TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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01960	Continued From page 42 The findings include: R1's diagnoses included schizophrenia, type II diabetes, hypertension and panic attacks. R1's service plan dated August 10, 2021, indicated R1 was receiving services to include: activity assistance, bathing, bedmaking, medication administration, blood glucose monitoring, oxygen, and vital signs. R1's signed provider orders dated August 16, 2021, indicated R1 was receiving medications and treatments to include: - aspirin 81 milligram (mg) daily - Bumex 2 mg two times daily - carvedilol 3.125 mg tablet two times daily - colace one capsule two times daily - Detrol LA 4 mg tablet daily - Humulin R U-500 subcutaneous three times per day - Lantus 100 unit/milliliter subcutaneous per day - lisinopril 2.5 mg tablet daily - oxygen two liter per nasal cannula continuously, if less than 92% notify registered nurse (RN) - blood glucose monitoring four times per day R1's medication administration record (MAR) dated June 2022, indicated oxygen daily two liters via nasal cannula as needed to keep oxygen saturation above 90%. R1's oxygen saturation record dated June 1, 2022, through June 21, 2022, indicated the icensee was monitoring oxygen two times daily in the mornings and evenings. On June 21, 2022, through June 22, 2022, the surveyor observed R1 seated by the main	01960		

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	35716	A. BUILDING: _____ B. WING _____	06/22/2022

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01960	Continued From page 43 entrance with her oxygen concentrator but it was not in use both days for the duration of the survey. On June 22, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-C acknowledged R1 was not using her oxygen as prescribed but stated the licensee will clarify orders with provider. The licensee's Treatment and Therapy Management policy dated August 1, 2022, indicated the licensee's RN will provide coordination of treatment or therapy activities with prescriber, but lacked verbiage to include receiving and implementing provider orders. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=G	144G.91 Subd. 4 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) who utilized bed rails with record reviewed.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35716	A. BUILDING: _____ B. WING _____	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUTTERFLY BOUND CARE	3207 67TH AVENUE NORTH BROOKLYN CENTER, MN 55429

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02310	Continued From page 44 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on December 31, 2019. R1's diagnoses included diabetes and congestive heart failure (CHF). On June 21, 2022, at approximately 10:30 a.m., the surveyor observed R1's hospital bed with bilateral bed rails which were rectangular shaped and measured approximately 13 inches in width and 8 inches in height (in the mid-section). Each bed rail was one piece on either side of the bed with crossbars opening to less than approximately four inches wide. The bed rails were well fastened to the bed on both sides. R1's Side Rail Assessment Form dated March 15, 2020, signed by R1 and registered nurse (RN)-A, indicated R1 consented to have a bed rail installed properly for positioning. R1's service plan dated August 10, 2021, indicated R1 received services including medication management, bathing, bedmaking, dressing, linen change, behavior management, meal assistance, blood glucose, oxygen, and shopping assistance. On June 21, 2022, at approximarely 10:50 a.m., RN-A and licensed assisted living director	02310		

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02310	Continued From page 45 (LALD)-C acknowledged R1's bed rail had no documented measurements. RN-A also stated they were not aware of the measuring requirement. The licensee's Side Rail Use policy dated August 1, 2021, indicated the licensee will assess the use, educate the resident, provide risks verses benefits to the responsible person regarding the side rails and verify the side rails are of safe design and utilized consistent with the manufacturer's direction. The policy lacked verbiage to include taking side rail measurements. The Food and Drug Administration's (FDA), A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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

Type: Full
Date: *06/21/22*
Time: 11:00:00
Report: 1013221168

Food and Beverage Establishment Inspection Report

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.

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.

COLD TCS FOOD MEASURED ABOVE 41F INSIDE THE REFRIGERATOR: COOKED VEGETABLES 46F, MILK 72F, EGGS 44F. PER STAFF THE MILK WAS LEFT OUT DURING BREAKFAST. COMPLY WITH ABOVE RULE. STAFF ADJUSTED THE REFRIGERATOR COLDER, MONITORED TEMPS, AND DISCARDED FOOD.

Comply By: 06/21/22

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

NO SANITIZER WAS USED IN THE KITCHEN. REUSABLE WARE AND SURFACES WERE WASHED WITH SOAP AND WATER. BREAKFAST DISHES WERE AIR DRYING DURING THE VISIT. COMPLY WITH ABOVE RULE. DISCUSSED WARE WASHING PROCEDURES AND SANITIZER USE. WARE WASHING GUIDE PROVIDED.

Comply By: 06/21/22

4-300 Equipment Numbers and Capacities

4-302.12A ** Priority 2 **

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO FOOD PROBE THERMOMETER CAPABLE OF MEASURING HOT AND COLD TEMPERATURES WAS AVAILABLE. TCS FOODS ARE HELD AND COOKED ON-SITE. RAW MEATS AND EGGS ARE COOKED ON-SITE. COMPLY WITH ABOVE RULE. REVIEWED THERMOMETER USE WITH STAFF.

Comply By: 06/21/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO SANITIZER TEST KITS WERE AVAILABLE (CHLORINE OR QUATERNARY AMMONIUM). COMPLY WITH ABOVE RULE.

Comply By: 06/23/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO MN CFPM WAS EMPLOYED AT THE FACILITY. THE OPERATOR HAD A CURRENT FOOD MANAGER'S COURSE CERTIFICATE. COMPLY WITH ABOVE RULE. THE MN CFPM APPLICATION WAS PROVIDED.

Comply By: 09/21/22

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

COOKED VEGETABLES DATE MARKED 6/19 AND BREAKFAST LEFTOVERS WERE STORED IN THE REFRIGERATOR. PER STAFF THE FOOD WAS TO BE SERVED LATER. THE KITCHEN EQUIPMENT WAS RESIDENTIAL AND NOT CERTIFIED BY AN ANSI ACCREDITED PROGRAM. COMPLY WITH ABOVE RULE.

Comply By: 06/21/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

GREASE AND GRIME WERE ON THE INSIDE OF THE OVEN AND THE OVEN HANDLE. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 06/21/22

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 72 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Milk 2
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: *06/21/22*
Time: 11:00:00
Report: 1013221168
Butterfly Bound Care

Food and Beverage Establishment Inspection Report

Process/Item: Cooked vegetables
Temperature: 46 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

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

The inspection was completed with the operator and reviewed with MDH Nursing Evaluator B. Nyangena.

The establishment has a residential kitchen. The kitchen has wood cabinets, granite counter tops, wood floor, and a popcorn ceiling. The kitchen finishes and surfaces were well maintained. When updated the ceiling and floor need to be smooth, durable, easily cleanable, and nonabsorbent.

A 2 basin sink is located in the kitchen. One basin was designated for hand washing.

The dish machine was not working. The dish machine should be replaced with one that is certified to NSF/ANSI standard 184. This will allow for proper sanitizing of ware. Ware washing can be done manually at the sink using a container with sanitizer mixed at the proper concentration.

MN CFPM information: https://www.health.state.mn.us/communities/environment/food/cfpm/index.html

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, date marking, cleaning, food storage, and food handling procedures.

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 1013221168 of 06/21/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Selina Birabwa
Operator

Signed: JM
Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us