Electronically Delivered

November 13, 2025

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

RE: Project Number(s) SL32914016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32914	A. BUILDING: _____ B. WING _____	10/21/2025

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

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0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32914016-0 On October 20, 2025, through October 21, 2025, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the provider's Assisted Living Facility 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced 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	0 680		

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0 680	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: - annual review; - quarterly review of missing resident policy; - arrangements with other facilities; - roles under a waiver declared by secretary; and - emergency prep testing requirements. On October 20, 2025, at 2:40 p.m., licensed assisted living director (LALD)-A stated they were working on updating the EPP; however, the updated plan had not been completed yet. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff during periods of emergency or disaster that disrupts service. In addition, the licensee would implement the Emergency Management program as soon as the agency became aware of the existence of an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 3 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 20, 2025, at 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: EXIT DOOR LOCKING - An exit sign was posted at the back door, and a sliding bolt lock was installed at the top of this door. The back door was labeled as an exit on the posted evacuation floor plan. The installed height and style of this bolt lock would delay exiting in the event of an emergency. The sliding bolt lock was removed while the surveyor was	0 775		

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0 775	Continued From page 4 onsite. CLOTHES DRYER MAINTENANCE - There was an accumulation of lint behind and above the clothes dryer in the basement, creating a fire hazard. This lint accumulation indicated the venting system had not been maintained. ELECTRICAL - An extension cord was attached to the wall and used to supply power to a flat screen television in occupied resident room 3. Electrical extension cords shall not be used as a permanent power supply. - Two power strips were daisy chained in the living room and used to supply power to multiple electronic devices, creating a fire hazard. During the facility tour interview, LALD-A verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=E	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	0 800		

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0 800	Continued From page 5 by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 20, 2025, at 11:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: SHARED BATHROOM MAIN FLOOR - A handle or knob was not installed on the interior side of the sliding door, making it difficult to open and close. - One section of the shower floor trim was cracked. BUILDING MAINTENANCE - In occupied resident room 3, there was a hole in the closet door. - In occupied resident room 1, there were two holes in the closet door. - The interior side of the closet door was cracked	0 800		

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0 800	Continued From page 6 at the main front entrance. - Inside and outside the basement bathroom, there was unfinished drywall. During the facility interview, LALD-A stated these areas had been recently repaired and the facility was still working on this project. - There were several lights that did not work in the basement. During the facility tour interview, LALD-A stated the light bulbs required replacement. PRIMARY ENTRANCE SIDEWALK Between the driveway and front door, several areas of this sidewalk were chipped, creating an uneven walking surface. EXTERIOR DECK - One chair was in disrepair. - The deck finish was peeling with rough surfaces in multiple locations. - One screw was exposed on the deck railing. The deck shall be maintained in a condition that does not create a safety risk to residents. During the facility tour interview, LALD-A verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810		

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0 810	Continued From page 7 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and maintain required drill documentation. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 8 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 20, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP floor plan failed to accurately identify the location and number of resident sleeping rooms and an egress window evident by the following: On October 20, 2025, at 11:30 a.m., the surveyor toured the facility with LALD-A. During the facility tour, the surveyor observed the following: - Number identifiers were posted at the resident sleeping room doors. The posted FSEP floor plan did not include number labels for these resident sleeping rooms. Sleeping room number labels must be included on the FSEP floor plan and correspond with the numbers installed at the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. - A window not meeting egress escape requirements in occupied resident sleeping room	0 810		

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0 810	Continued From page 9 1 was inappropriately labeled as an exit on the posted FSEP floor plan. Accurate egress window labels are required on the FSEP floor plan in order to direct the building occupants to designated exits in the event of an emergency. Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants evident by the following: - The FSEP had been created using templates from third party providers. Pull fire alarms were inaccurately referenced. - The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. - The FSEP failed to include specific fire safety and evacuation instructions for residents evident by a lack of these procedures in the plan. The FSEP was limited to directing residents to stoop or crawl to avoid smoke. - The FSEP included standard resident evacuation procedures, but failed to provide evacuation procedures that included individualized unique needs of residents evident by a lack of these procedures in the plan. During an interview on October 20, 2025, at 1:50 p.m., LALD-A verified the FSEP was lacking the above content. DRILLS	0 810		

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0 810	Continued From page 10 Record review indicated the licensee failed to maintain evacuation drill records to support employee drills were conducted twice per year, per shift evident by a review of fire drill reports lacking the required documentation. The shift or time was not recorded on the 2024 December and October fire drill logs. During an interview on October 20, 2025, at 1:50 p.m., LALD-A verified the evacuation fire drill documentation was lacking. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a	0 910		

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0 910	Continued From page 11 violation that has not 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 R1 was admitted and began receiving services October 9, 2020. R1's service plan dated April 4, 2025, indicated R1 received services which included assistance with medication administration, dressing, grooming, toileting, exercise, transfers, eating, housekeeping, laundry, and "I'm okay" checks. R2 R2 was admitted and began receiving services October 19, 2019. R2's service plan dated August 1, 2025, indicated R2 received services which included assistance with medication administration, dressing, grooming, toileting, exercise, transfers, eating, housekeeping, laundry, and "I'm okay" checks. R3 R3 was admitted and began receiving services May 22, 2021. R3's service plan dated August 13, 2021, indicated R3 received services which included assistance with medication administration, blood glucose management, dressing, grooming, toileting, incontinent care, positioning, exercise,	0 910		

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0 910	Continued From page 12 transfers, eating, housekeeping, laundry, transportation, and "I'm okay" checks. R1, R2, and R3's records included a Resident contract for Assisting Living dated August 21, 2021, August 21, 2021, and July 27, 2021, respectively. The contracts all lacked the licensee's Health Facility Identification Number (HFID). On October 21, 2025, at 1:46 p.m., licensed assisted living director (LALD)-A stated the licensee had an outside consultant assist with the drafting of the current contract, and was not aware the contract was missing information. LALD-A further stated the contract R1, R2, and R3 signed was the contract they had been using for all the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32914	A. BUILDING: _____ B. WING _____	10/21/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 920	Continued From page 13 other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three resident (R1, R2, R3). This practice resulted in a level one violation (a violation that has not 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 R1 was admitted and began receiving services October 9, 2020. R1's service plan dated April 4, 2025, indicated R1 received services which included assistance	0 920		

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	32914	A. BUILDING: _____ B. WING _____	10/21/2025

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

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0 920	Continued From page 14 with medication administration, dressing, grooming, toileting, exercise, transfers, eating, housekeeping, laundry, and "I'm okay" checks. R2 R2 was admitted and began receiving services October 19, 2019. R2's service plan dated August 1, 2025, indicated R2 received services which included assistance with medication administration, dressing, grooming, toileting, exercise, transfers, eating, housekeeping, laundry, and "I'm okay" checks. R3 R3 was admitted and began receiving services May 22, 2021. R3's service plan dated August 13, 2021, indicated R3 received services which included assistance with medication administration, blood glucose management, dressing, grooming, toileting, incontinent care, positioning, exercise, transfers, eating, housekeeping, laundry, transportation, and "I'm okay" checks. R1, R2, and R3's records included a Resident contract for Assisting Living dated August 21, 2021, August 21, 2021, and July 27, 2021, respectively. The contract lacked a disclosure of the licensee's ability to provide specialized diets. On October 21, 2025, at 1:46 p.m., licensed assisted living director (LALD)-A stated they had an outside consultant assist with the drafting of the current contract, and she was not aware the contract was missing information. LALD-A further stated the contract R1, R2, and R3 signed was the contract licensee had been using for all the	0 920		

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	32914	A. BUILDING: _____ B. WING _____	10/21/2025

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0 920	Continued From page 15 residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked and substantially constructed compartment according to the manufacturer's directions and permit only authorized personnel to have access for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted and began receiving services	01880		

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01880	Continued From page 16 October 9, 2020. R1's service plan dated April 4, 2025, indicated R1 received services which included assistance with medication administration, dressing, grooming, toileting, exercise, transfers, eating, housekeeping, laundry, and "I'm okay" checks. R1's medication list dated September 11, 2025, included Trulicity (for diabetes) 0.5 milligrams subcutaneously (SQ) (under the skin) once weekly and Basaglar insulin (long-acting insulin-for diabetes) 10 units (u) SQ in the morning. R2 R2 was admitted and began receiving services October 19, 2019. R2's service plan dated August 1, 2025, indicated R2 received services which included assistance with medication administration, dressing, grooming, toileting, exercise, transfers, eating, housekeeping, laundry, and "I'm okay" checks. R2's medication list dated August 5, 2024, included Aspart insulin (fast-acting insulin, for diabetes) 2 u SQ with breakfast, 2 u SQ with lunch, and 2 u SQ with dinner along with sliding scale, depending on blood glucose levels, and glargine insulin (long-acting insulin, for diabetes) 5 u SQ daily. On October 21, 2025, at 9:35 a.m., during medication storage observation with unlicensed personnel (ULP)-E, the surveyor observed the following medications stored in licensee's unlocked community refrigerator, in licensee's kitchen, where residents' food was also stored:	01880		

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	32914	A. BUILDING: _____ B. WING _____	10/21/2025

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01880	Continued From page 17 - R1: one unopened Trulicity injection pen and one unopened Basaglar insulin injection pen. - R2: three unopened insulin aspart injection pens and one unopened insulin glargine injection pen. On October 21, 2025, at 1:25 p.m., licensed assisted living director (LALD)-A stated she was not aware the refrigerator where medications had been stored was required to be locked. LALD-A further stated she was under the impression that their only responsibility was to ensure they documented the refrigerator temperature daily. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated when licensee was providing storage of medications outside of the resident's private living space, all prescription drugs would be securely locked in substantially constructed compartments, according to manufacturer's directions, only authorized personnel would have access to the stored medications, and medications requiring refrigeration would be stored in an enclosed container or area separate from food. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 18 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. 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 prescription number if applicable, quantity, and to whom the medications were given, upon discharge from the facility for one of one discharged resident (R4). 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: R4's discharge care plan dated May 5, 2025,	01910		

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01910	Continued From page 19 indicated R4 was admitted to the licensee's facility on July 6, 2024, and received services, which included medication administration, dressing, grooming, and bathing reminders, behavior management, housekeeping, and laundry. The care plan indicated R4 was discharged on May 5, 2025. R4's active medications at discharge summary, dated May 5, 2025, included atomoxetine HCL 25 milligram (mg) indicated for (attention deficit activity disorder), Cariprazine HCL 1.5 mg (indicated for mood disorder), clonidine 0.1 mg (indicated for anxiety), and Tylenol 1,000 mg (indicated for pain). R4's undated discharge nurse note provided to surveyor on October 20, 2025, indicated discharge papers, medication list, and a list of R4's providers was sent with R4 upon discharge. R4's record lacked evidence of documentation of R4's disposition of medications to include prescription number if applicable, quantity for tylenol 1000 milligrams, and to whom the medications were given, upon discharge from the facility. On October 20, 2025, at 2:05 p.m., licensed assisted living director (LALD)-A stated she had counted R4's medication and had handed them to R4 upon discharge. LALD-A further stated she had not documented medication disposition due to being not sure of the requirement. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated the disposal and disposition of discontinued medications for residents who	01910		

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01910	Continued From page 20 received the medication management program would be completed in a safe manner by appropriate personnel. Furthermore, unused portions of current medications being managed by the facility would be given to the resident upon discharge, and a note regarding this would be placed in the clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

BUTTERFLY BOUND CARE
6207 CHOWEN AVENUE NORTH
Brooklyn Center, MN 55429
Hennepin County
Parcel:

Phone:

License Info

License: HFID 32914

Risk:
License:
Expires on:
CFPM: Martha Isanka
CFPM #: 60548; Exp: 08/05/2028

Inspection Info

Report Number: F1051251146
Inspection Type: Full - Single
Date: 10/20/2025 Time: 11:00:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, RHONDA MAKELA.

DISCUSSED THE FOLLOWING WITH THE FOOD SERVICE MANAGER, MARTHA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1051251146 from 10/20/2025

Martha
Food Service Manager

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

BUTTERFLY BOUND CARE
Brooklyn Center
County/Group: Hennepin County

Inspection Info

Report Number: F1051251146
Inspection Type: Full
Date: 10/20/2025
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No