STATE LICENSING COMPLIANCE REPORT

Report #: HL357172281C

Date Concluded: June 30, 2025

Name, Address, and County of Facility Investigated:
Butterfly Bound Care
3501 62nd Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35717	A. BUILDING: _____ B. WING _____	C 05/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL357172281C On May 30, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were three residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL357172281C, tag identification 0450, 0485.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 1 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide services in a person-centered manner. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to ensure it provided appropriate service to maintain the residents' dignity. On May 30, 2025, at 12:05 p.m., the investigator observed a resident's room with a commode in it. The basin of the commode was wrapped in a plastic bag and had urine in it. A disposable chux	0 450		

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0 450	Continued From page 2 pad underneath the commode had urine on it. A door leading into the garage from the kitchen was observed to be open. On June 3, 2025, at 10:50 a.m., a resident's case manager stated she had been in the home and observed mice and roaches and a resident lost "several hundred dollars" worth of food that had gotten eaten by mice at the facility. The case manager stated the facility was dirty and the resident got sepsis twice while living at the facility. The case manager stated the facility didn't provide even basic housekeeping and when they'd ask to get things deep or steam cleaned, the owner would hire a family friend to come Lysol wipe things down. The case manager stated the facility would receive reimbursement for providing direct care and services like bathing and homemaking or socialization, but "that never happened." The case manager stated the facility never did housekeeping and there were infestations in the facility. On May 30, 2025, at 12:50 p.m., a facility resident stated the facility was supposed to be doing his laundry and housekeeping but it often did not get done. The resident was wearing visibly soiled clothing and the resident's room appeared messy and cluttered. The resident stated some staff did not know how to use the washer and he would have to show them. The resident stated he wanted to have help with housekeeping and laundry and thought they were supposed to be doing that but stated they rarely did. The resident stated the facility was supposed to help him with rides to get to appointments but he would also have to do that himself. On June 4, 2025, at 11:00 a.m., R1 stated the facility was "nasty" and had roaches and mice. R1	0 450		

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0 450	Continued From page 3 stated no one was ever bathed at the facility and there was always a smell of ammonia in the house. R1 stated licensed assisted living director/licensed practical nurse (LALD/LPN)-A offered him $2,000 to move into the facility. R1 stated he knew his waiver was paying the facility $443 per day to live there and he didn't feel they were providing the services they were supposed to be doing. R1 stated no one ever came in his room to clean it and when he broke his collar bone, staff couldn't understand he needed emergency services called and he had to call 911 himself. R1 stated he would often see other residents walk around in dirty or saturated incontinence products and the facility would be left unsupervised at times. R1 stated he had to pay rent on top of what his waiver was paying the facility and didn't feel he got the care or services he was paying for. On June 9, 2025, at 12:20 p.m., LALD/LPN-A stated the facility had been "battling" a lot with roaches due to residents bringing stuff in off the street and they had an exterminator come in. LALD/LPN-A stated there were mice in the facility because the residents would frequently leave the doors open and people would be coming into the facility as late as 3 or 4 a.m. and mice would get in the facility. LALD/LPN-A stated housekeeping services were completed as scheduled but since there were two dogs that lived in the facility, they were constantly trying to clean up after the dogs who would urinate or poop in the facility or track mud in. LALD/LPN-A stated she thought they would have to close the facility because it had gotten so hard to manage. LALD/LPN-A denied offering a financial incentive to R1 to move in. No further information was provided.	0 450		

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0 450	Continued From page 4 TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
0 485 SS=F	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure at least three nutritious meals daily, according to the recommended dietary allowances in the United Stated Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive	0 485		

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0 485	Continued From page 5 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: Four weeks of the licensee's menus were provided. The menus included breakfast, lunch, dinner, and two snacks per day. Menu selections included: Friday: Breakfast: Juice, french toast, sausage links, cantaloupe Lunch: Corn dogs, baked beans, milk and water Snack: Celery and peanut butter, milk Dinner: Steak cubes, coleslaw, angel food cake with strawberries, milk, and water Snack: ice cream sundae and milk Saturday: Breakfast: Juice, cold or hot cereal, bagel, grapes/oranges Lunch: Deli sandwiches, chips, celery, milk, and water Snack: pudding and milk Dinner: Roast with vegetables, rolls with butter, fresh strawberries and blueberries, milk, and water Snack: Client choice with milk Sunday: Breakfast: Juice, scrambled eggs, sausage links, toast, yogurt Lunch: Client choice, milk, water Snack: Chips and salsa Dinner: Baked salmon, asparagus, strawberries with whipped cream, milk, and water Snack: Fruit cup with milk	0 485		

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0 485	Continued From page 6 Monday: Breakfast: Juice, pancakes, bacon, choice of fruit Lunch: Fish sticks, tarter sauce, french fries, milk, and water Snack: Client choice and milk Dinner: Ham, stuffing, potatoes, brownie, milk, and water Snack: Fresh veggies with dip and milk Tuesday: Breakfast: Juice, eggs made any way, hash browns, toast Lunch: Leftovers, milk, and water Snack: Fruit cup and milk Dinner: Walking tacos, pineapple pieces, milk, and water Snack: Mixed nuts and milk Wednesday: Breakfast: Juice, cold or hot cereal, cinnamon rolls, bananas Lunch: BBQ chicken, fries, milk, and water Snack: Client choice and milk Dinner: Sloppy joes, chips, mixed vegetables, blueberry muffins, milk, and water Snack: Yogurt and milk The licensee's UDALSA (Uniform Disclosure of Assisted Living Services and Amenities) dated May 13, 2021, indicated breakfast, lunch, and dinner were available in a community space. Three meals with snacks were available, as required. On May 30, 2025, at 11:50 a.m., unlicensed personnel (ULP)-B showed the investigator the refrigerator in the kitchen of the facility. Contents of the refrigerator included sour cream, mayonnaise, margarine, tortillas, apple juice, and a quart of milk that had about a cup of milk in it.	0 485		

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0 485	Continued From page 7 The freezer had chicken nuggests and french fries. The investigator asked ULP-B if there was a dry storage pantry for things like cereal and she stated any dry goods were stored in a pantry at another facility operated by the licensee. ULP-B confirmed the only food in the house for meal preparation was located in the refrigerator that was just observed. The dining area lacked a table for residents to sit at for meals. A small table was observed in the dining room area that had a toaster and toaster oven. ULP-B was asked what was being served for lunch as it was nearly lunch time and there was no preparation observed to be happening. ULP-B stated she would have to get food from the other house the licensee operated as they prepared it. ULP-B was the only person working in the facility at the time. On May 30, 2025, at 12:00 p.m., a facility resident stated the facility rarely prepared meals for residents and the residents normally cooked food for themselves. The resident stated they could tell facility staff to cook something and they would usually cook chicken nuggets for them. The resident stated facility staff would bring her to the food pantry so she would have food to prepare for herself. The resident had a refrigerator in her room which contained cheese and margarine. A loaf of bread was observed on a table in the resident's room. On May 30, 2025, at 12:10 p.m., a facility resident stated the facility didn't really cook meals for them but they could ask staff to make something and they usually would. On May 30, 2025, at 12:15 p.m., the resident asked ULP-B when she was going to feed him. On May 30, 2025, at 12:17 p.m., licensed	0 485		

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0 485	Continued From page 8 assisted living director/licensed practical nurse (LALD/LPN)-A arrived at the facility. LALD/LPN-A stated the facility provided three meals per day and snacks and stated the food would be in the fridge at the facility. LALD/LPN-A was told there was not any food to prepare meals in the facility. LALD/LPN-A then stated the food manager would prepare the meals at another facility owned by her and they would bring lunch over. On May 30, 2025, at 12:20 p.m., ULP-B left the facility to get food from another facility owned by LALD/LPN-A. ULP-B returned at 12:25 p.m. with two plastic bags. ULP-B showed the investigator the contents of the bag which included two frozen pizzas, two ribs, and a plastic disposable container of pasta. ULP-B microwaved the two ribs and brought the pasta and ribs to one of the residents. The investigator did not observe food being offered to the other two residents in the facility. On May 30, 2025, at 12:50 p.m., a facility resident stated there usually was not much for food in the facility and facility staff would not prepare meals for residents. The resident stated they could ask staff to cook something but the only thing they were ever fed was chicken nuggets and fries and he would get sick of eating chicken nuggets. On June 3, 2025, at 10:50 a.m., a resident's case manager stated they had brought up concerns with availability of food to LALD/LPN-A on numerous occasions as the county was paying the facility to provide food to the residents and meals were not being provided. On June 4, 2025, at 11:00 a.m., R1 stated the facility did not provide meals for residents and if you wanted food, you had to ask for it, and even	0 485		

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0 485	Continued From page 9 then it would only be chicken nuggets or frozen pizza. R1 stated facility staff would often say the office was closed so they weren't able to go get any food. On June 4, 2025, at 12:30 p.m., LALD/LPN-A stated the menu provided wasn't used as the residents did not like the foods on the menu and every resident liked different things. LALD/LPN-A stated since they all like different things, the residents will tell staff what they want to eat and they will make it. LALD/LPN-A stated residents liked chicken nuggets and pizza and they would put snacks in the resident's personal refrigerators. LALD/LPN-A was asked what snacks would have been placed in the personal refrigerators as they were all observed and the investigator did not note any snacks. LALD/LPN-A stated they would provide chips, cookies, and cake for snacks as that's what the residents liked. LALD/LPN-A stated most food was kept at another facility down the street so staff would have to go there to get any food items they needed. LALD/LPN-A confirmed the facility would be left unsupervised if only one person was working and had to leave to go to the other facility to get food. LALD/LPN-A was asked if the facility had worked with the residents to create a menu they approved of if they did not like the one they had created. LALD/LPN-A stated no because all the residents like different things. No further information was provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		